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ABSTRACT

A project was undertaken at Baptist College in Charleston, South Carolina to develop a two-year associate degree program to train paraprofessional home health personnel to promote family health in rural areas. After receiving the contract, the college recruited a project director to serve in its Natural Sciences Division. The project director worked together with representatives from the faculty, local health care providers, and health educators from other colleges to develop a proposed curriculum. The curriculum turned out to be a 66-credit program designed to prepare students to provide community- and family-based health supportive services in the areas of disease prevention and health promotion. The curriculum, which had a strong natural science base, focused on the biological and psychological aspects of human health and included studies in religion, sociology, and communication skills. During the course of the program development effort, project staff organized and implemented community and faculty workshops and developed a variety of resource materials, including project brochures, instructional materials, seven separately bound instructor resource guides, and evaluation forms. (Appended to this report are the project brochures, evaluation forms, and excerpts from course materials.) (MN)

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Rural Health Promotion ...

A SERIES OF MATERIALS SUPPORTING AN ASSOCIATE DEGREE

ED237709

A FINAL REPORT ON THE
PARAPROFESSIONAL RURALLY ORIENTED
FAMILY HOME HEALTH TRAINING PROGRAM

THE DEVELOPMENT OF
AN ASSOCIATE DEGREE IN

RURAL HEALTH PROMOTION

philosophy
administration
evaluation
products

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developed for
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Office of Vocational and Adult Education
Contract No. 300-81-0436

THE DEVELOPMENT OF AN ASSOCIATE DEGREE IN RURAL HEALTH PROMOTION

PHILOSOPHY
ADMINISTRATION
EVALUATION
PRODUCTS

A FINAL REPORT ON THE

PARAPROFESSIONAL RURALLY ORIENTED
FAMILY HOME HEALTH TRAINING PROJECT

developed by
the Division of Natural Sciences
the Baptist College at Charleston
Charleston, South Carolina

Project Director
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developed for the
U.S. Department of Education
Office of Vocational And Adult Education
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FORWARD

Early in the Summer of 1983, an advertisement in a local newspaper requested applications for the position of "paraprofessional to teach nutrition in the rural areas of the state." At that time, this project report on the development of a "paraprofessional rurally oriented family home health training program" was being outlined. The advertisement brought up the question that has repeatedly surfaced during the work on this project - "What IS a paraprofessional?

The Random House Dictionary defines a paraprofessional as "a person trained to assist a professional." The prefix PARA means "along side, similar to, subsidiary to..."

In the newly developing profession of health promotion, there are educational programs preparing people at the Doctoral level and related degrees at the Master and Bachelor level (usually in public health or health education). The Associate degree in Rural Health Promotion that is described in this report and its appendices is designed to train the lowest level of this career ladder - to produce an aide or assistant who will work along with professionals providing Health Promotion services to communities in a variety of fields.

The tasks of health promotion (and disease prevention) are complementary to, but often different from, the tasks of disease treatment. In 1979 the U. S. Department of Health, Education and Welfare published a vital new report from the Surgeon General of the United States called Healthy People. That report and its background papers defined steps to be taken toward "a healthier America." The thesis of the Surgeon General's report was that "further improvement in the health of the

American People can and will be achieved - not alone through increased medical care and greater health expenditures - but through a renewed national commitment to efforts designed to prevent disease and promote health." The report goes on to explore risk factors and prevention strategies focused on life style and behavior of individuals, families and society as a whole.

The Associate Degree in Rural Health Promotion is one more step in that defined commitment to pursue the goals of optimum health for <u>all</u> Americans. It focuses on the under served rural areas of this country.

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all on the faculty at the Baptist College at Charleston at the time of this project

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SECTION I
PHILOSOPHICAL DEVELOPMENT

PHILOSOPHICAL DEVELOPMENT

Using Paraprofessionals to Promote Better Rural Health

The Associate Degree in Rural Health Promotion was developed out of concern for the health status of Americans in rural areas. Behind the development of such a paraprofessional degree lie certain definitions and assumptions about rural areas and the health problems they face. In the development of this project, in the determination of its goals and methods, it was necessary to define the parameters of rural health, to explore the needs of rural populations both in the present and in the future, and, eventually, to determine the possible role of paraprofessionals in meeting those needs.

What Is Rural?

Defining what we mean by the term "rural" is vital to any consideration of the needs of rural Americans. Most people have an idealized image of what rural life implies - a quiet, rustic, simple life which revolves around the church and the farm. Like the comedian's story of retiring to a chicken farm, the real and the ideal are not very close together. William H. Friedland, in an article in The Journal of Rural Sociology in 1982, suggests that if we base our definition of rural on the concept of a type of homogeneous agrarian culture, with unsophisticated, provincial, leisurely life-style, then we will find few rural areas left in the United States. This country has seen the development of an urban - rural continuum in terms of population densities which blurs any clear cut geographical definition, producing "fringe" areas with combination characteristics.

So called "reverse" migration to lower density areas, as well as the effects of modern news and entertainment media, have resulted in "country" communities where many of the basic conditions of urban life are reproduced. John M. Wardwell of Washington State University (in Rural Society in the U.S.:Issues for the 1980's) reports that the reverse migration, begun in the 1970's, is supported not only by a desire to live in rural areas but also by the fact that the "desirable aspects of urban living" are now available in rural areas as well. Of the populations in rural areas, 24% of the whites and 11% of the blacks were recent arrivals - coming originally from urban areas. While total rural population size has changed little since 1920 and urban populations have often tripled, growth rates of non-metropolitan areas have often exceeded that of metropolitan areas by a factor of 2:1, with many nonmetropolitan counties often gaining population during the early 1970's.

While these population trends have changed the flavor of country life in many areas, they have not yet altered the basic fact that rural areas are less densely populated. In the United States approximately 25% of the population lives on 90% of the land, with specific densities ranging from 200 per square mile near urban areas to one per ten square miles in the western mountains. We can count on rural being more accurately measured by population density than specific characteristics of the society found in these areas. We can also count on a great heterogeneity of other characteristics. Rural no longer implies farming in all parts of the country - farmers make up only a small part of modern rural society, even if we consider the increasing frequency of the part-time farm. Not only have farms become "agribusiness," the proportion of farmers in

rural areas has dropped from three out of five country residents in 1920 to one out of five in 1970. while the midwestern rural resident is still likely to be involved in farming, the Appalachian rural populations organize their lives around the mining industries, and the Carolina rural populations include large percentages of textile workers.

There are some characteristics that rural areas hold in common besides lower population. While individuals and special sub-populations may defy these trends, rural populations do seem to have:

* twice the poverty rate as cities
* more under- and un-employed adults
* lower educational status
* higher percentages of the population made up of children, the elderly and the poor

Thus, rural populations do differ demographically from urban populations. This difference leads to a consideration of the health needs and resources of the urban American, since the three distinct sub-populations mentioned above, children, the elder and the poor, have more health needs than the average citizen.

Health Problems and Resources of Rural Populations

To quote from the Summer Issue of Rural Sociology, page 326,"One of the traditional myths about country life is that the people are healthier - plenty of good food, clean air, lots of physical exercise etc. make rural folks sounder in body and mind. Studies based on military inductions and other health data show that, in fact, rural people are not as healthy as urban dwellers." For example, a recent research report (highlighted in the August 1983 issue of the American Rural Health Newsletter)

by Merle Sargent of the University of Idaho, states that there is a higher death rate in rural areas than in urban areas of that state. Of equal interest, the report states that the causes of these deaths are lifestyle related - stress, lifestyle, environment.

Similarly, the Georgia Rural Health Association reports that rural Georgia has 39% MORE heart disease deaths, 56% MORE stroke deaths, 83% more motor vehicle deaths, and 29% more death in general than urban Georgia. A report on rural rehabilitation, by Michael Leland and Mary Jo Schneider of University of Arkansas, points out that 8.5 million disabled Americans live in rural areas. Regardless of our vision of country life as healthier, proportionately more rural citizens suffer from heart conditions, arthritis, mental illness, high blood pressure, visual impairment, etc. than their urban "cousins." Infant mortality rates are higher in rural areas, rural residents suffer from high alcohol use and from the resultant disfunction, disability, deaths, and automobile accidents.(e.g.,"Rural Students and Drug Use," reported in Rural Sociology , 1981, widespread use of both alcohol and marijuana in rural populations. Also "Overview of Mental Health in Women in Craig, Colorado" available from University of Wisconsin - Extension in Madison, reports extensive alcoholism among this population as well)

At the same time, rural areas suffer from fewer services to aid the chronically ill. Leland and Schneider point out that rehabilitative services are either "severely restricted or non-existent." A report on Health Care Delivery in Rural Areas by the American Medical Association points out that rural areas lack both manpower and organization of services. The U.S. Department of Agriculture Bulletin 428, Health Care in Rural America

shows the following figures for available medical personnel.

area type	medical personnel/100,000 population
metropolitan	157
non-metro.	71
rural (near urban)	35
rural (far from urban)	37

The problem is not with acute care - hospitals are often equally accessible to the urban dweller, the suburban dweller and the rural resident (at least in terms of access time - "from my house to seeing the doctor" , according to Bulletin 428 noted above). Rather it is the type of life-style oriented services, focusing on chronic and preventative care, obviously badly needed by the rural resident, which are not available. This is an age - old problem; as Hippocrates said, " Healing is a matter of time, but it is sometimes also a matter of opportunity." Senator Mark Andrews, from North Dakota, points out in August 1983 Issue of American Rural Health Newsletter that in the last 12 years great strides have ben made in providing access to medical facilities. The Area Health Education Centers, established in 1971, have greatly enhanced access to medical care for rural populations. But in the April 1983 issue of the same newsletter, Robert DeVries and Joan Cleary point out that a growing interest in comprehensive health services and in health promotion will mean that health care institutions will need to become more involved in cooperative community activities, in addition to the services they provide in treatment.

Certainly one way of approaching these problems is to increase the numbers of traditional health professionals who serve rural areas. This has proved to be easier said

than done; physicians and nurses are costly to train and costly to support, if not for the area they serve then for society as a whole. While many areas employ National Health Service Corps personnel, few doctors remain in rural areas; they cite as deciding factors - longer hours required, limited availability of continuing medical education, limited interaction with peers, less sophisticated medical support, and limited social, cultural, and educational opportunities for their families, among others. With the low rural tax base and simpler governmental units, these "unattractive" features are unlikely to change.

Moreover, the U.S. Surgeon General's Report on Healthy People states that major gains in the health status of Americans in general will not be made by increasing access to traditional treatment alone, but will also require enhanced emphasis on promotion of disease preventative life styles. This leads to the next important issue.

Where Does Health Promotion Fit In?

The article mentioned above by DeVries and Cleary mentioned an increasing interest in health promotion. The U.S. Surgeon General's report links many of the lifestyle illnesses (mentioned as specific problems of rural areas) to common behavioral causes and points out that "personal decisions required to reduce risk from one disease can reduce it for others."(pg.10)

In addition, perhaps one of the most direct measures of how the concept of health promotion applies to rural areas can be seen in the interests of rural health care providers and researchers. The focus on health promotion planned for the Fall meeting of the Georgia Rural Health

Association is health promotion. The 1983 meeting of the South Carolina Public Health Association included no less than four papers summarizing health promotion efforts in rural counties. Similarly, the Eighth Annual Institute of the American Rural Health Association, to be held in June of 1984 is entitled "Exploring Frontiers of Rural Health" and has at least one major health promotion topic on its agenda - stress/mental health in rural areas. In fact, stress in rural populations may turn out to be a major health risk - certainly a perceptual dissonance for most ideas of rural living. Psychology Today , October 1983, reported on work done which showed an increasingly high incidence of stress related illnesses in rural residents. Since research into what makes a job stressful (Girdano and Everly, The Stress Mess Solution) indicates that ambiguity of outcome, lack of control over very important issues, vital decisions with little time and less valid information all lead to high occupational stress, it would hardly be surprising if agricultural workers, at least, were stressed.

Health promotion is playing a major role in health planning at many levels in the 1980's. The last part of this century has seen a significant shift in U.S. patterns of mortality and morbidity. Today, over 75% of all deaths result from illnesses or conditions clearly related, at least in part, to life style. While improvements in health and life span in the first half of the twentieth century have resulted primarily from improved treatment and prevention of infectious diseases, the next "revolution" which will enhance the quality of health is expected to come from the promotion of healthier life styles - with a focus on the individual and those factors which influence the chosen behaviors of the individual.

The synergistic interaction of life-style elements

means that health promotion efforts cut across and link apparently diverse areas of illness. The major death and disability issues share many common causes and interactive exacerbating factors:

* exercise and fitness
* concern over what we put into our body:
  in the form of foods,
  tobacco (nicotine, smoke,CO,etc),
  alcohol, and
  other drugs
* living in high stress environments

The 1979 U.S. Surgeon General's report on Healthy People identifies these common causes as risk factors to be targeted in the 1980's. These same factors transcend the variety of settings which help to shape the attitudes and actions of individuals - settings including the work place, the family, the schools and the society as a whole, be it urban or rural.

In this same vein, but focused on the needs of rural areas in particular, the Health Care in Rural America report suggests that communities train residents to serve as paraprofessionals in health care provision, from EMS(Emergency Medical Services) services, to basic first aid, and on to health promotion and health education. Thus the link betwen health promotion and the use of paraprofessionals - the last philosophical issue in the development of this project.

The Use of Paraprofessionals in Rural Health Care

Eva J. Salber and her co-workers in North Carolina addressed the need for increased access to life-style health care/education by exploring the usefulness of "health facilitators" or "lay advisors". (Community

Health Education - the Lay Advisor Approach, Duke University, 1979) Their project sought to "promote good health and prevent illness rather than concentrating on the cure of illness alone" by using lay members of a community who have received "training in promotive health practices, prevention of disease, in early recognition of illness together with first aid measures."

Actually, use of paraprofessionals is not uncommon. In other countries, paraprofessionals are often used in educational and health promotion programs, as an important part of the total health care delivery system. In a recent American Public Health Association Study of 180 health projects in developing countries (reported by Royal D. Colle in a paper prepared for the 2nd International of the World Federation of Public Health Associations, Canada, 1978) 92% of the projects studied used paraprofessionals in providing health education as a major part of the primary health care to rural populations. The American Medical Association, in Health Care Delivery in Rural Areas, focused on the United States, defines the elements of an ideal rural model health system. This model includes, along with traditional professionals and services, the use of "health aides- recruited from the local community" and the provision of "preventative care...outreach case finding, home care", all often provided by paraprofessionals. This same model suggests citizen health education and community college programs for training aides.

Numerous "model" programs highlighted by the AMA report use paraprofessionals and health promotion programs. The Central Pennsylvania Health Council in a five-county area of rural Pennsylvania uses health educators, nutritionists, paraprofessionals for emergency treatment centers, and provides home health programs,

"weight watchers" programs, and other ancillary services. The Mountain Peoples Health Council (Tennessee) reports using health aides and outreach workers along with traditional medical professionals to provide health care.

The AMA report summarizes its findings in part as follows: "...small towns can identify their own nurses, active or retired technicians, teachers who have health skills, or others who can be trained to perform relatively simple but nonetheless critical services." (emphasis is added) "The key focus is community consciousness. ...the objectives are to interest each individual in his own health and the means to improve it, to teach him where health services are available, to motivate him to use these services intelligently,and to teach him what aspects of personal behavior and the environment will affect his health."

The First National Conference on Models of Rural Social and Health Delivery of Services agrees. Reported by Joylean Sampson and Gloria Jenkins (available on microfiche) the conference proceedings note the use of allied health workers - skilled paraprofessionals who can serve to extend services beyond the physician.

In A Sociology of Health by Andrew C. Twaddle and Richard M. Hessler, the authors state that "...of all the strategies for improving medical care for the (rural) poor, the substantial increase in new nonphysician medical manpower is possibly the most important innovation..." Even in the areas of mental health (as discussed in Mental Health of Rural America ,NIMH and The Nonprofessional Revolution in Mental Health by Francine Sobey) paraprofessionals from rural communities have been used effectively. Part of the introduction to Sobey's book comments, "Nonprofessionals are being trained for new service functions and roles, in many cases roles that were

not previously being played at all in the mental health program."

Although most of the training for such paraprofessionals, in both the mental and physical health areas, began as informal training programs, in many cases expanded programs soon became important. Twaddel and Hessler discuss the problem of insufficient training, both in terms of its impact on lay workers' competency and in terms of their acceptance by existing professional care givers. This is in addition to the impact on upward or outward mobility of the paraprofessionals themselves. They quote one paraprofessional as saying -

> "I don 't have a degree, so if I left here I may have to go ... back to business machines. I don't really feel secure. If something happens you have to try and get a job. You should at least get an associates degree in college."

Twaddel ends the section on Community Health Workers with these thoughts, " ...the seed has been planted for changes in health manpower. If health care is to be made available to all as a right, on the order of public education, then change must occur...The community health worker program has provided a model for the creation of a new occupational hierarchy."

These then are the philosophical and conceptual components which shaped the development of the Associate of Natural Sciences in Rural Health Promotion:

1. the realities and myths of rural existence
2. the need for enhanced health care in rural areas based on chronic life style illnesses and on-going inadequate numbers of treatment professionals
3. the perceived and experienced strength of

utilizing community paraprofessionals

4. the training insufficiencies defined by both professionals and the paraprofessionals themselves

The Rural Health Promotion Associate Degree, the concept, curriculum, and courses do not reflect ideas that are new to health. Instead, they draw upon several maturing themes. As mentioned in the preceding sections, the concepts of health promotion and disease prevention as one major focus for rural health, the use of trained paraprofessionals from rural communities, and - as implied by the U.S. Surgeon General's report on healthy people (1979) - the confluent or holistic nature of the behavioral components (causitive and ameliorative) of life-style illnesses. These concepts have been used to develop an integrated, state of the art approach to personal and community health enhancement - the paraprofessional degree in rural health promotion. Since this degree presumes to prepare the paraprofessional to deal with a holistic model of human health (embodying biological, psychological and spiritual aspects), and with tasks in education and and community networking, it was designed to include learning

1. in the cognitive concepts relating to the biological and biochemical functioning of the body
2. in the theory and application of psychological constructs
3. in the inter-relationship of these two academic areas dealing with mind and body
4. in the contextual areas of religion and sociology
5. in the practical application of basic skills in English, mathematics, and oral communication

and

6. in the application of this set of knowledge and skills to health promotion through paraprofessional tasks and settings.

The rest of this project report presents the Administrative, Product Development, and Evaluation components of this contract as well as a discussion of the strengths and weaknesses of both the products and the process which produced them.

SECTION II
ADMINISTRATIVE DEVELOPMENT

ADMINISTRATIVE DEVELOPMENT
of a
Paraprofessional Training Program for
RURAL HEALTH PROMOTION

As of September 30, 1983, the Baptist College at Charleston has successfully developed a 2-year paraprofessional degree designed to enhance the health status of rural Americans. The initial proposal for the degree was responsive to national data indicating "less than adequate access to health personnel and educational offerings" in rural areas as well as the poorer health status of rural residents.

The Original Contract

Goals: In 1981 the Baptist College entered into a contract (No. 300-81-0436) with the U. S. Department of Education, Office of Vocational and Adult Education to

1. design, develop, and field test a "paraprofessional rurally oriented home-family health training program"
2. implement a pilot testing program
3. evaluate the effectiveness of the program
4. disseminate information about the program

The deliverables for this contract were:

1. A Project Abstract
2. A Plan of Work
3. Quarterly Reports
4. Financial Reports
5. Design of an Informational Flier
6. Survey of Needs Report
7. Curriculum Outline
8. Drafts of Training Modules

9. Final Training Modules
10. Criteria for Evaluation of Materials and Program
11. Evaluation Reports on Materials and Program
12. Workshop Outlines
13. Promotional Materials
14. Distribution Lists
15. Project Reports

Time Lines: The original time line for this project began in November of 1981 with the preparation of the project abstract, a brief summary of the intentions of the project along with proposed plan of work. It was to proceed through 1982 and conclude in September of 1983.

The identification of the curriculum component courses and the rough draft of these materials was to be done during 1982, with revision of the materials accompanying the teaching of a trial group of courses to 10 students in the Spring Semester of 1983. Accompanying this work was to be the development of promotional materials and methods in the form of brochures, workshops, and mailouts, and the implementation of these procedures. The actual evaluation of the program was to occur in summer of 1983, with final reports and products to be provided to the Office of Vocational and Adult Education in the fall of 1983.

Administrative Structure: The Baptist College at Charleston recruited a project director, to be a member of the faculty with the rank of Assistant Professor of Natural Sciences. The Natural Sciences Division of the College was an appropriate home for the rural health project for several reasons - (1) the Natural Sciences Division was already the site of a two year degree program in Nursing and was involved in cooperative educational activities with the Medical University of South Carolina,

located in nearby Charleston; (2) the preliminary design of the rural health curriculum proposed to include two major tracks - physical care and psychological care; both the biology and psychology departments are part of the Natural Sciences Division. As the project developed into a degree focused on the new national concern for health promotion from a holistic perspective (the U.S. Surgeon General's Report on Healthy People), this administrative site in a Division which taught both mental and physical health basics was even more appropriate.

The Project Director reported directly to the Vice President for Academic Affairs in charge of the Division of Natural Sciences and also to the Assistant Vice President for the Development of Special Projects. This allowed the Project Director access through regular faculty channels to the curriculum committee (vital for the development and offering of new academic courses and degrees) and access to the budgetary and planning professionals of the college.

One of the first tasks the Project Director undertook was to form two advisory committees or boards. A Faculty/Academic Advisory Committee was made up of representatives from the various divisions of the college and was given the task of helping to define the content of the proposed curriculum in terms of academic concerns. The Community Advisory Committee was made up of representatives from the community who were (a) providers of health care or health education in general, (b) health educators at the college level, (c) health care providers who utilized paraprofessional level employees. The Community Advisory Committee helped to define the possible academic content in terms of necessary and appropriate skills and knowledge for use by paraprofessionals in community settings.

The only other staff person who was employed by the Rural Health Project was a project secretary, who also served in a limited way to provide public and professional information in the absence of the Project Director. The development of the modules (writing and teaching course materials) and the evaluation components of the program were to be the task of consultants, hired for those specific activities only. The Project Director provided information to these consultants defining and guiding their work. In addition, a general consultant from the medical education field was contracted to help in the initial delineation of the scope and process of the project.

Consultants were sought from the entire Charleston academic community (comprised of the Baptist College at Charleston, the Citadel Military College, the College of Charleston, the Medical University of South Carolina, and Trident Technical College) as well as from the practicing health education community (contacted primarily through the local Tricounty Health Educators Coalition, recipients of a state award for contributions to health education)

Changes in Administration During the Project

Focus: As a result of work with the Community Advisory Committee, the focus of the two year Associate degree in rural health was moved firmly away from any intersection with nursing or with counseling/social work and provided with a clear health promotion/health education identity of its own. The reasons for this were essentially three: (a) concern for overlap with existing degrees in the area (and nation); (b) concern for lack of clarity legally with regard to the tasks the graduate might preform, and with regard to certification; and (c)

desire to produce a state of the art program utilizing the most recent perceptions of the health needs and directions of the nation.

The academic focus was also changed somewhat by the influence of both the Faculty/Academic Advisory Committee, the Community Advisory Committee and the background readings done by the Project Director. Much of the work done with paraprofessionals seemed to emphasize the need for more sophisticated training, both for use in the worksite and for mobility of the graduate. The focus moved from one of clear-cut task descriptions and limited training modules to one of broad background learnings in areas of relevance to the understanding of the tasks and techniques of prevention/health promotion followed by only a few specialized courses where skills of relevance primarily to rural health students were developed. There were several reasons for this change.

(a) First, there was a clear need in the community for paraprofessionals who have learned material at a traditional college level. In part this was because of the need to relate to professional health care givers and be seen as "well prepared". However, there was also a strong need to provide a broad enough background so that the graduate could move into the wide variety of settings now using paraprofessionals. For example, in the Charleston, South Carolina area alone paraprofessionals are used in alcohol and drug detoxification facilities, in residential alcohol and drug treatment, in residential homes for unmarried mothers, with the local hot-line and in help centers, in Hospice settings, in community stress management education, in school based primary prevention, in nursing homes, in Senior Citizen centers, in drug and alcohol out reach programs, in Department of Agriculture extension nutrition programs, many others. No one set of

skills would serve all of these sites; each site would require further learning on the part of new employees based on some common educational ground.

(b) By using a core of existing courses on the Freshman and Sophomore level, a college can implement the two year Rural Health degree with minimal new faculty and new courses. It allows rural health students to take part in classes with other students at the school instead of proceeding lockstep in an insular fashion (as some, but not all, nursing programs). Therefore the students are provided with increased chance to explore their own and other people's values and perceptions - an important task to be accomplished prior to trying to help others change their health related behaviors. In addition it opens up the program to other students to enhance enrollment and provide for easier introduction of the curriculum into a college's budgetary structure.

There was also a move away from several specialized tracks and toward the inclusion of both physical and mental health background and skills in the same program, clearly reflecting the movement nationally in health care and health education to confluent, holistic views of human health and health behaviors.

Changes in Staff: In September 1982, the first Program Director, Ms. Susan Wallace, left the project to move to anotherg state. The second Program Director, Mrs. Donna Foster Myer, was appointed as of November 1, 1982. This was a smooth changeover since Mrs. Myer had been working with Ms. Wallace for several months on the Health Promotion Seminar course. However, since there was no specific administrative overlap of the two Directors, some loss of continuity did occur. Later in the project, in the summer of 1983, two changes of secretarial staff severely disrupted the final stages of the project.

Changes in Deadlines and Deliverables: By the time the first project director, Ms. Susan Wallace, left the college in 1982, the "field testing" had been changed to an evaluation of the project components, but not of program graduates, since it had become obvious that design, development, and implementation could not be accomplished in the 18 month period available in the contract. Ms. Wallace had overseen the development of a two year curriculum which drew heavily on already existing core courses at BCC (also common to other liberal arts colleges). "New" courses specialized to the needs of the new degree had been developed in detail by BCC faculty and other consultants and draft versions of these courses had been accepted by Washington. Several of the new courses had been passed by the BCC Curriculum committee for 1983 offerings by the time the second Project Director joined the project in November 1982.

In all five changes were made in time and type of deliverables.

1. the final draft of the training modules was changed from late in 1982 to just prior to completion of the project
2. and 3. the final evaluation report was changed in form to be a qualitative report on concept and content of the degree rather than field testing, and the time was changed from mid-summer 1983 to just prior to the completion of the project
4. and 5. the dates of the final modules and evaluation reports were changed to coincide with the final report in September of 1983.

The final changes were made in response to severe illness in the Project Director's Family, but they were insufficient. The severity of the illness kept the

Director from regular duties for several months, setting back the completion of the project.

Administrative Strengths and Weaknesses

The most obvious weakness was the initial decision to have only one full time employee at the faculty level - the Project Director. When difficulties arose with the person in this position, there was no one with the complete knowledge to compile the final products. Although administrative staff at the college were aware of the flow and focus of the project, none of them were familiar enough with the day to day activities and the content of the final packages to fill in for the Project Director during the latter stages of the contract. Then, too, no other staff were paid for such a task and personnel monies had been expended on contracted products and activities. Change over of secretaries at this same critical period further retarded the production of final documents.

However, the only impact was upon time of completion. Both in format and content, the various deliverables of the contract were produced as expected.

The major strength of the program's administration lay in the use of the Advisory Committees and contracted consultants, as well as its administrative location within the Natural Sciences Division of the College. The advisory Committees helped to shape appropriate and reasonable directions for the project and its products. Access to professionals in a variety of fields meant that products were produced that joined the expertise of faculty in a variety of areas, allowing the Project Director to make sure the courses were sufficiently but not excessively inter-related. The location of the project in the

administrative structure of the Natural Sciences (with strong supportive input from the Department of Sociology) also meant that the products were credible in a variety of diverse fields.

Retrospective Time Lines and Mile Stones: From January 1982 through October 1982, the project focus was on the choice of the specific curriculum content and production of initial drafts of the course modules. These items are presented in more detail in the section on product development, in the evaluation, and in the appendices. The informational flier presenting the concept of the project to other educational professionals had been developed and distributed in the Spring. A Survey of Needs had been made. The curriculum outline was accepted by the College and the Office of Vocational and Adult Education in June of 1982.The Curriculum itself was made-up of 66 credits in regular semester college courses, with 22 of these accounted for by seven "new" courses developed by the project. These courses, in rough draft form, were presented to the Office, of Vocational and Adult Education in September 1982. They included - Interpersonal Communication-Techniques and Styles; Epidemiology; Chemistry for the Life Sciences; Health Care Organization and Issues; Health Promotion Seminar; and Fundamentals of Physical Care (later renamed Paraprofessional Care) I and II. One of the first responsibilities of the second Project Director was to consult with The Office of Vocational and Adult Education regarding revisions in these materials.

In the late fall of 1983, the format and content for a faculty workshop were developed and submitted. Faculty consultants were contracted to work with the new project director during the January Inter-term of the College to develop materials which would ensure the continuity and

compatibility of the curriculum components, drawn as they were from such a variety of academic areas for a two year degree. At the same time, alternative plans for "field testing" some of the components of the curriculum were developed and accepted by both the College and the Office of Vocational and Adult Education.

During the Spring Semester of 1983 the project focused on the refinement of the curriculum, course materials and support materials through developmental teaching of selected new courses. Continued background readings, use of consultants from the fields of rural health, health promotion, and health education and early key informant data evauation of the concept of the program resulted in minor changes in direction and some major changes in components. Other faculty were actively involved in the development of core area Rural Health Focus Guides (not one of the original deliverables, but an outgrowth of the faculty workshop in January). The development of materials and workshops to publicize the program state-wide were also begun.

A student - oriented brochure was produced and extensively disseminated. Community workshops for practicing professionals, paraprofessionals, and potential students were organized. In the spring of 1983, the Curriculum Committee of the Baptist College at Charleston voted to approve an Associate Degree in Rural Health Promotion (an Associate of Natural Sciences Degree) for formal offering in the 1983-84 Catalog, to be published in the Fall of 1983.

Also during the Spring 1983, evaluation plans were developed and implementation was begun of the qualitative evaluation of concept and content covered in greater detail in Section IV of this report. In the Summer of 1983, workshops of varying length were offered in three

parts of the state and evaluation of the project in terms of the concept of the degree and the specific content of the courses was begun using key informant data. (The results of one part of this evaluation caused the re-naming of the Physical Care courses as Paraprofessional Care and made major changes in the intent of these course; the early evaluation also resulted in the inclusion of background materials as an introduction to each course module)

Late summer saw the beginning of the staffing difficulties for the contract. Two changes of secretarial staff in 6 weeks and severe illness in the Project Director's immediate family intervened not in the definition or content of the final reports, but in their compilation and reproduction until mid-December, 1983.

A summary of the major accomplishments of this project (as delivered to the Office of Vocational and Adult Education in December 1983) are listed below:

1. A 66 credit liberal arts based health promotion curriculum was approved by Baptist College at Charleston and the U.S. Department of Education. The associate degree which this curriculum represents is included in the Fall 1983 Catalog of the Baptist College at Charleston.

2. Seven specialized courses required by the above curriculum design were developed - Interpersonal Communication Techniques and Styles,; Health Care Organization and Issues; Health Promotion Seminar; Introductory Epidemiology; Chemistry for Life Sciences; Fundamentals of Paraprofessional Skills I and II. A special design for associate degree field experience was also developed.

3. A two-day work shop orienting faculty to the program and curriculum goals was held in January 1983. This workshop brought together faculty, rural health

sociologists, and rural health care providers and recipients; it included the development and distribution of a detailed notebook comprised of an overview of national health promotion goals, rural health issues, and cultural considerations of rural health promotion.

4. Special rural health focus guides were written as a result of the above workshop, to allow instructors of core courses to consider a special focus on rural health concepts while retaining the course goals of academic studies in English, biology, mathematics, religion, sociology, etc.

5. During the revision and evaluation phase, eleven core courses and four newly designed courses were part of a developmental field teaching of both courses and support materials specialized to support the program.

6. Community workshops and student recruitment brochures were developed to publicize the program.

7. The program was publicized through general state-wide and national mailing of the program brochure, through Public Health and Health Education meetings, and through extensive mailing to clergy.

8. A qualitative evaluation gathered responses from rural communities on the proposed graduates of the program and from health professionals on the content of the courses.

9. A final project summary report discussed conceptual, developmental, and applications issues including

a) the compiled responses of the evaluation of concept and content and

b) appendices with the seven specialized courses developed by the project and the support materials for the core courses of the program.

SECTION III
PRODUCT DEVELOPMENT

PRODUCT DEVELOPMENT

The products which will be discussed in general in this section include the curriculum itself, the workshops for community and faculty, the project brochures for professionals and potential students, the information distribution, and the specific courses developed for the program - Interpersonal Communication, Chemistry, Epidemiology, Health Promotion Seminar, Paraprofessional Skills I and II, and Health Care Organization and Issues. For each of these products, the process and product will be discussed in general, as well as strengths and weaknesses. In most cases, the specific product is included in this report as an appendix (in the case of the instructor guides to the courses, bound separately).

Proposed Curriculum

Process: The choice of the specific courses to be included in the two year preparation of a rural health paraprofessional (with and emphasis on health promotion) was made as the result of the input of both Community and Faculty/Academic Advisory Committees. Certainly the content was effected by the fact that the project was funded from the Office of Vocational and Adult Education and was contracted to a private college with a clear emphasis on liberal arts. Perhaps in some senses the two are mutually exclusive; the orientation of vocational "training" having often been that of definedterminal behaviors, with the focus on specificity of objectives in well defined situations; while liberal arts "education" has been oriented toward broad general objectives, with the focus on the ability to think your way through new situations.

Any process which links two such different approaches can result in either the best of both or the worst of both; this project appears to have taken the former course. In this case, the Faculty/Academic Advisory Committee and the academic staff of the college responsible for the project made sure the content of the curriculum was sufficiently inclusive to produce a graduate with the breadth of knowledge that characterizes holistic health and health promotion. The Community Advisory Committee and the liaison and advisory staff from the Office of Vocational and Adult Education made sure the rationale for the inclusion of each course was specific to some aspect of the type of job performance which might be expected of a paraprofessional.

In a similar fashion, the courses themselves were pushed toward a clear definition of concepts and specific objectives, coupled with clear statements of areas open to individual instructor discretion and development. The overall assumption of the courses is that the instructor of each will be chosen because of his oe her demonstrated expertise in the field, that each is aware of the basic content and methodology of the discipline, and that only where some specific approach has been selected does the instructor's guide need to specify method of teaching.

The initial task for describing the curriculum content was to define the minimum skills and knowledge needed by the graduate. Ideally this should have occurred prior to preliminary choices for the curriculum; in reality, the process was cyclic. The initial ideas were drawn from the experiences of the Community Advisory Committee; these ideas were then used to define a preliminary curriculum; at the same time the Project Director was exploring the literature in the field and becoming familiar with the experience pro and con in the

use of paraprofessionals. The expectations of health promotion from a holistic perspective were then superimposed upon this content. The end result was a definition of a graduate with certain general abilities, backed up by the courses needed to ensure the acquisition of these abilities, backed up at a third level by the courses needed as prerequisites to the "skills" courses and the applications. Thus -

the ultimate goal of the program - to prepare graduates who will be able to

enhance health of rural residents through activities in disease prevention/health promotion, including facilitation of more effective use of existing treatment resources and better personal and family health decisions

the areas of knowledge and skill needed to reach the ultimate goal -

I. a cognitive understanding of health

A. body -

* anatomy and physiology
(which needs chemistry)
(which needs basic math)

B. mind -

* psychology
(which needs reading ability and writing ability)

C. illness -

* general understanding of symptoms, causes and treatment
(which needs microbiology and epidemiology)
(which need chemistry)

* life cycle information
(which needs physiology and human

growth and development)

D. health behavior change

* promotion skills
(which need psychology and interpersonal communication skills

* knowledge of risk factors
(which needs anatomy and physiology and nutrition)

II. a cognitive understanding of health systems and community systems

A. health systems
(which need a knowledge of sociology and human services in general)

B. community systems
(which need an understanding of sociology, religion, group dynamics and interpersonal communication)

III. a need for a spectrum of paraprofessional level skills

A. interpersonal and intervention skills
(which need interpersonal communication, psychology, and group dynamics)

B. basic home-health care
(which needs basic understanding of illness, epidemiology, anatomy and physiology)

C. first aid skills
(which require basic knowledge in anatomy and interpersonal communication)

D. liaison skills

* referral and linking
(which require knowledge of systems, interpersonal communication)

* evaluation and explanation

(which requires interpersonal communications skills, health knowledge and verbal and written skills)

IV. a need for ability to communicate both "up" and "down"
   A. health knowledge
   B. verbal skills
      * interpersonal communication
      * group dynamics
   C. writing skills
      * English
   D. knowledge of systems
      * human services
      * health care organization and issues

V. a need to fit into the community and be able to function there as a "change agent" for individuals and families
   A. understanding of personal mind sets and values
      * interpersonal communication skills
      * English
      * psychology
      * religion
   B. ability to understand the mind sets and value systems of others
      * interpersonal communication
      * English
      * psychology
      * sociology
      * religion
   C. experience relating to others in health issues
      * paraprofessional skills
      * interpersonal communication

* health promotion seminar
* health promotion practicum

Product: When courses were chosenthey were chosen tc fit into the needs and goals listed above. The actual degree and the required courses are excerpted from Baptist College registration materials on the next three pages. Although this listing includes the specific course designation at the Baptist College at Charleston (e.g. Math 121), the descriptions should be specific enough for interpretation in other college systems. In addition, for the general core courses and for the individual courses developed by this project, a section of the Instructor Guide (appendices, bound separately) is titled "The Role of _____ in Rural Health Promotion Training." These sections are included bound in this volume, as are the tables of contents of the individual courses.

BAPTIST COLLEGE at CHARLESTON

ASSOCIATE IN NATURAL SCIENCES DEGREE
IN RURAL HEALTH PROMOTION

The Associate Degree in Rural Health Promotion is a 66 credit program which prepares students to provide community and family based health support services in the areas of disease prevention and health promotion.

This degree has a strong natural science base (33 credits) to build understanding of the biological and psychological aspects of human health. It includes studies in religion and sociology, as well as written and spoken communication skills which are relevant to effective intervention in social and interpersonal settings. To focus this basic knowledge on disease prevention/health promotion, specialized courses provide understanding of health care organizations and issues, health promotion methods, fundamentals of paraprofessional care and a prevention/promotion practicum experience.

COURSE REQUIREMENTS
(* indicates courses developed specifically for this program)

Department	Course	Credits
English 111, 112	English Composition and Rhetoric:	3,3
	Courses designed to improve students ability to express themselves accurately and effectively in writing	
*Speech and Drama 120 (Natural Sciences 120)	Interpersonal Communication-Techniques and Styles:	3
	This course will teach techniques of good interpersonal communication including specific skills in listening, decision making, observation, assessment, interviewing, and group process. It will explore the effect of individual attitudes and beliefs on communication as well as cultural characteristics of communication and barriers to communication.	
Math 111	General College Mathematics:	3
	A course in general math skills with an emphasis on application.	
or		
Math 121	College Algebra:	
	A course for students already proficient in general math skills.	
Pyschology 200	General Pyschology:	3
	An introduction to concepts underlying the understanding of behavior.	
Psychology 320	Human Growth and Development:	3
	An overview of human development psychologically for conception through senescence, with an emphasis through adolescence.	
Psychology 322	Psychology of Adulthood and Aging:	3
	A study of development during adulthood.	

Department	Course	Credits
Sociology 201	Principles of Sociology:	3
	A focus on the ways sociology provides understanding of group behavior and human relations.	
Sociology 401	Introduction to Community Services:	3
	Introducing the organization, methods, settings of community social services.	
Religion 112	Survey of the New Testament:	3
	The content of the new testament.	
or		
Religion 208	Introduction to Group Dynamics:	3
	Religious and psychological principles applied to interpersonal relationships and group functions.	
Biology 210	Anatomy/Physiology:	4
	A study of human structure and function with emphasis on the body systems.	
Biology 220	Microbiology:	4
	Study of micro-organisms with emphasis on normal and pathological conditions in man and environment.	
*Biology 303	Epidemiology:	3
	A study of the inter-relationship among organisms, the environment, and man. The course develops an understanding of the history of disease, their signs, symptoms, and prevention. It provides a working knowledge of the terms; morbidity, mortality, acute disease, and chronic disease. Basic data are presented concerning the application of demographics, community health care, and the epidemiologic study of the causal factors of disease. Prerequisites: Biology 220	
Biology 345	Nutrition:	3
	Concepts of human nutrition applied to health and disease, world hunger, and personal nutrition.	
Chemistry 110	Concepts of Chemistry:	4
	Key principles needed in allied health and liberal arts.	
	HEALTH PROMOTION SPECIALITY COURSES	
*Natural Science 201	Health Care Organization and Issues	3
	The purpose, functions, and administration of community health care services, public and private. A study of issues affecting health care utilization and delivery; consumerism, ethical issues, and future technology. Prerequisites: Sociology 201, Psychology 200.	

Department	Course	Credits

*Natural Sciences 202 Health Promotion Seminar: 1

A cognitive presentation of the major areas of emphasis for health promotion - exercise, concern over what we put into our bodies (foods, alcohol, tobacco, and other drugs), and living in high stress environments - and concommitant presentation of the major techniques of personal responsibility and personal change. The course requires application of these concepts to develop experiential knowledge in behavior change. It will also develop critical consideration of emerging health promotion ideas in both professional sources and the popular media. Prerequisites: Sophomore status

*Natural Sciences 205, 206 Fundamentals of Paraprofessional Care I and II 4,4

Development and application of knowledge and paraprofessional skills in physical care, emotional support, personal hygiene, and safety/first aid. Acute and chronic conditions will be covered. Working knowledge of medical terminology and consumer oriented pharmacology. Laboratory experiences complement the lectures and include certification in Cardiopulmonary Resuscitation. Prerequisites: Chemistry 110; Biology 210, 220, and 345, Interpersonal Communications 101; Psychology 320.

*Natural Science 210 Practicum in Health Promotion 3

Application of classroom knowledge in community based programs related to health promotion/disease prevention. During the first two weeks of the Semester and the last week of the Semster, this class will meet 3 hours per week on campus to structure the students' practical experiences and discuss class assignments and requirements. The reminder of the semester the course will consist of 9-12 hours/week of experience in a community based program and one class meeting per week on campus. Prerequisites: Fundamentals of Paraprofessional Care I, Sociology 401-Introduction to Community Services.

ELECTIVE(S)

It is suggested that any electives be drawn from the following courses: 3

Sociology 202 - Social Institutions
Sociology 324 - Sociology of Religion
Religion 112 - New Testament
208 - Group Dynamics
340 - Psychology of the Religious Experiences

Health and
Physical Ed. 101 - Aerobics and Physical Fitness
202 - School Health
211 - Recreation Programming
404 - Physical Education for the Exceptional Student
380 - Physiology of Exercise

Any electives to be approved by the advisor.

Strengths and Weaknesses: The evaluation of the concept and content of this curriculum is detailed in Section III: Evaluation. However, it is appropriate at this point to discuss what we believe are the major strong and weak points of this curriculum.

The major strength of the curriculum is related to the process of its development. It covers sufficient background information to have the potential to produce a graduate who can continue to learn and who has certain higher cognitive level skills such as interpretation, synthesis and analysis. It also has applications courses which require the acquisition of specific skills - interpersonal communication, paraprofessional skills, health promotion seminar, health promotion practicum. These courses were developed by practitioners in the field who did not just "educate" people but who were responsible for "training" them, with definable exit level skills.

A second strength is that the broad liberal arts core allows the program to be implemented in most colleges without the need for extensive new courses. This also allows for integration of the students in this course of study into the total college student body, which is a positive component in learning about others who are "not like me" (a prerequisite to effective functioning as a change agent in the field of health promotion)

This same general core makes the graduate able to continue their education toward the bachelors level if they are so inclined. In a similar way, the program could be flexible enough to serve as a minor in schools which offer this option, and as a minor it would be of value to persons in business and personnel administration (health promotion is "big business" in business these days), in religion (where the health of the person is often a major area of ministry), in education (where educating the whole

person is effected by the health status of that individual), in health and physical education, in sociology or psychology. Indeed, the first few students who have enrolled in the program at the Baptist College at Charleston have pointed out that it simply prepares them to function more effectively in their communities and families regardless of the formal occupations with which they later become involved.

The major weakness may not be a weakness at all. The primary response to this program has been that it is not "easy;" that the student who is interested in a two year degree rather than a four year degree is usually less able, less "bright," and less well prepared. Although the latter may well be correct, there is no reason for it to always be true. In addition most colleges have systems to alleviate deficits in high school preparation. The first two assumptions may be true for some students, but the "elite-ism" that they produce has all the characteristics of conventional ethnic prejudice and may well have been detrimental to higher and continuing education over all. Although we are becoming a more highly educated nation, there simply are not enough jobs which require a four year degree for effective functioning to employ all of our "best" students.

A second weakness of the program is similar to all other comprehensive two year degrees - there is little flexibility. In addition, such rigidly defined requirements may make it hard for the small school to provide this program, since small schools often offer many of their courses on an alternating year basis. This weakness might be overcome by defining a "minor" in health promotion based on this curriculum, thus creating a larger potential enrollment of students for the specialized courses.

Over all, however, the feeling is that this two year degree in health promotion will do a better job of preparing functional community change agents in a variety of health settings and health related occupations than do many existing four year programs. Although there are 5 students currently with a status of having enrolled in the program, it remains to be seen how they will fare in it and how the job market will see them after they graduate.

Workshop for Faculty

Intent: The rational for the faculty workshop was originally to inform the faculty about the existence of the new degree and to elicit their support. It was held for two days during the January Interterm; faculty representing each of the core and special areas in the curriculum were invited to attend. Since a selection of courses from the program was to be taught during the following semester, a secondary goal was to provide these specific faculty with a broader view of the goals of the degree.

Process: In order to provide for more interaction between the faculty and the presenters in the workshop, a "task" was defined - to produce a written guide to each area in the core which would discuss ways to focus the core courses to more specifically meet the needs of a student enrolled in the rural health promotion associate degree. The format was informal, but guest speakers were chosen who would be able to present stimulating information (either new or from a new perspective) to the assembled faculty members.

Each participant was given a folder of prepared materials providing excepts from relevant readings. In addition, guest speakers provided some handouts.

Refreshments were supplied (by the project director, not from contract funds) and ample time was provided for discussion.

Specific Format and Content: A report on the workshops is provided on the next few pages. It includes the specific goals, the workshop components, the resources (both personnel and materials), information about the participants and how they effected the design, the workshop activities, and an overview of the packets of material handed out to participants. Following the report, a discussion of the results identifies the short and long term results as well as the strengths and weaknesses.

Interterm 1983
FACULTY WORKSHOP

In January interterm 1983, a workshop was held for faculty at Baptist College. The goals of this workshop were:

1. To familiarize the faculty with the projects's history, intent, and products.

2. To define RURAL, HEALTH, and HEALTH PROMOTION as they relate to the project.

3. To describe the graduate of the two-year degree program in rural health in terms of employment, competencies, future activities.

4. To explore issues of culture and ethnicity as they relate to all the courses of the program.

5. To discuss ways to focus new and existing courses on relevant issues for the rural health student without changing conceptural content or course objectives.

6. To generate support materials ("Rural Health Focus Guides") for each course. These guides would identify:
    a. special topics for existing student projects which would be directly related to rural health

    b. special examples for use by the instructor in lectures, homework, and testing which highlight areas relevant to rural health

    c. special resources and references instructors might use in teaching their subject areas to rural health majors

This was accomplished by the following WORKSHOP COMPONENTS:

1. introductory presentations by the Project Director and members of the Curriculum and Community Advisory Committees.

2. a presentation on the sociology of rural health and health services.

3. questions, answers, and discussion sessions.

4. brain storming and forcefield analysis around rural health needs including, as resources, representatives from rural areas who are providers/consumers of "health care".

5. prepared handouts and resource lists.

The workshop sessions lasted 3 hours a day for 2 days during the first week of January. During the third week of January, faculty briefly reconvened in workgroups, facilitated by the project director, to discuss their progress in developing the "Rural Health Focus Guides" for their respective courses and any further information needed for the field testing.

The participants for the January workshop were drawn from faculty responsible for the various courses of the curriculum as well as from other relevant support staff from the College. A minimum of 12 and a maximum 20 faculty and staff were to be involved. The participants covered areas of English, Mathematics, Psychology, Chemistry, Biology, Sociology, Religion, and health care.

WORKSHOP RESOURCES: PERSONNEL AND MATERIALS

In addition to the Project Director and the members of Curriculum and Community Advisory Committees, the following workshop resource people were utilized:

1. A medical sociologist from the Medical University of South Carolina - Thomas Watson, Ph.D., with experience utilizing paraprofessionals in rural health areas.

2. Al Mungin, the Executive Director of the St. James-Santee Rural Health Program Family Health Center in McClellanville, SC.

3. The Rev. Mr. Flectcher, Minister from McClellanville and part-time teacher at the Archibald Turledge Academy in McClellanville, SC.

Also used as resources for the workshop were the following materials:

The Mental Health of Rural America edited by Julius Segal, Ph. D., Published by DHEW, 1973

"Downeast: A Heavy Reliance on Volunteers"
"Secularly Employed Clergy"
"Community Care Givers"

Proceedings of a Sumposium on Culture and Health: Implications for Health Policy in Rural South Carolina edited by Mella S. Varner College of Charleston, SC. 1979.

Handbook of Rural Community Mental Health. Peter A. Keller and J. Dennis Murray. Human Sciences Press, 1982.

A Sociology of Health by Twaddle and Hessler. C.V. Mosby Company, 1977.

ABOUT THE PARTICIPANTS:

The faculty members who participated in this workshop were expected to have a broad range of awareness about the Rural Health Project and, indeed, about health issues in general. Several participants had authored course material for the project. Others had been used as general resources. Still others had only heard about the project and received general campus wide correspondence about the new courses being offered Spring Semester. Thus, the content of the workshop was designed to be comprehensive enough to inform those with only sursory knowledge and varied enough to maintain the interest of already knowledgeable faculty members. Since global goals for the workshop were to both broaden awareness and generate support during the field testing period, participants were involved in two roles - (1) as recipients of information and (2) as providers of professional input. The intent was to provide information to the participants in a creative, involving, profssiona credible, peer-to-peer basis. The input requested from the participants was not trivial; it was of clear importance, with specific guidelines but sufficient flexibility to provoke creative variation.

WORKSHOP ACTIVITIES:

Day 1 - informal sign-in, pick up of worksheet packets, beverages available

Introduction to Workshop by Donna Foster Myer, Director

A. The history, intent, and products of the project (utilizing audio-visual aids; refer to workshop packets)

B. Where this workshop fits in...an overview of goals. Expectations of director and of participants - discussion (both written on newsprint and posted)
C. The Potential Graduate of the program -
   1. competencies
   2. defined activities
   3. community sites and directions
   (use overhead projector)
D. Questions for participants

A DIALOG ON ISSUES by Donna F. Myer and Dr. Thomas Watson
Both presenters raised issues and responded to them. Leadership was shared. The format was informal (but highly planned). Input from the workshop participants was welcomed. A "recorder" person summarized input and posted written versions as the discussion proceded. Questions explored and terms defined:

*rural
*health
*health promotion
*paraprofessional
*the cultural concerns of health services
*the cultural concerns of health
*developing the necessary competencies

Informal brainstorming using stimulus questions.
"What role does a course in _____
play in producing a community health paraprofessional?"

Refreshments were available.

Summary of Day 1 - link to Day 2. Areas of concern in preparing the community health paraprofessional. The curriculum's impact - based on brainstorming.
Overview of Day 2:
Ways to focus courses on relevant issues for rural health care without changing conceptual content or course objectives

Day 2 - Informal sign-in

Introduction of guests

LOOKING AT RURAL HEALTH
1. Al Mungin, Executive Director of St. James-Santee Rural Health Family Health Center

2. The Rev. Mr. Flectcher, minister and educator, McClellanville, SC.

The McClellanville area of coastal South Carolina is rural by a variety of definitions - population density, access to services, primary employment patterns, family/social value systems, population history, and stability. Until recently, the health needs of the population were net only through travel to metopolitan areas. The imput from the guests focused on the defined competencies of the paraprofessional - relating these to the needs and realities they see in their rural community. Questions were solicited form the participants.

Force field analysis of impact of a course

Individual and small group work. How to focus you course to rural health concerns - suggestion for:

*special student topics
*intructor examples, for lectures, homework, testing

WORKSHOP PACKETS:

Each participant has received on Day 1 a pocket folder with the following materials:

1. An overview outline of the workshop sessions.

2. A list of workshop goals.

3. The project brochure; a short paper on history, current status and future tasks.

4. Excerpts form relevant writings on rural health, health promotion, and health paraprofessionals.
   A. Definition of Health
   B. Excerpts - U.S. Surgeon General's Report
   C. Demographic and Ethics Concepts Related to Disease
   D. Health Promotion Ideas
   E. Cultural Concerns in Helping People
   F. Paraprofessionals as Health Pacilitatiors

5. An annotated list of available books and journals related to rural health, including their location.

MEASURABLE OUTCOMES OF THE WORKSHOP:

The success of this workshop was measured in the following ways:

1. Attendance by invited participants.

2. Extent and quality of the "Rural Health Focus Guides" designed for the various curriculum areas subsequent the completion of the workshop.

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Results - Short and Long Term: The most immediate impact observed as a result of the workshop was that the participants refused to leave. This could also be considered as an evaluation component. After each of the two formal sessions, the speakers and faculty continued the discussions well past the closing time of 5 P.M. The other immediate result was discussion among faculty about health issues and health promotion concepts during lunch and free time for several weeks following the workshop. The Project Director was even asked informally to develop a health promotion plan for the faculty to be submitted to the Faculty Senate.

A slightly longer term result was the referral of students to the Project Director for possible enrollment in the program. One immediate result which was desired bu not obtained was faculty support for the developmental teaching of several of the courses in the Spring Semester in the form of student referral for enrollment. However, since preregistration had occurred the preceding November, this may have limited the number of students seeking courses in January registration.

The major long term result of the workshop was a series of Rural Health Focus Guides for the Core Courses which were of a sufficient quality that they have been bound separately as a appendix to this report. The approach of these products varied extensively; the faculty member from sociology became so interested in the concepts of health promotion and the issues of rural sociology that he wrote an extensive topic by topic guide to his course. Other faculty areas, such as mathematics, were more difficult to develop focus materials for and the guides produced were shorter. Some faculty members used the guides to argue in favor of providing a liberal arts background to the rural health promotion students; these

discussions are enlightening and coincide with the philosophy behind the project as a whole. Some of the science courses are so obviously vital to the rural health promotion student that little new material is needed to create a focus of relevance. In case, the author provided excellent ideas for obtaining and including specialized information by geographical area.

Strengths and Weaknesses: The Faculty workshop had many strong points. The content, concept, and format were well received and worked exactly as desired. The use of representatives from rural health clinics and "consumers" of rural health care made the content very real.

One major positive outcome of the workshop for the Project Director and for faculty who were involved in the Faculty/Academic Advisory Committee was the affirmation of the direction and content of the degree. The rural participants had not been briefed regarding the project except a short overview of the goals; instead they had been provided with a set of generic questions - for example,"What are the major health problems you see?" "In what way could paraprofessionals provide support in your community?" Even in the absence of detailed information on the direction of the project, the problems described by rural residents/service providers were of a life-style nature and one of the needs they defined was in the area of health education and promotion.

The workshop could have been further strengthened by inviting participants from other rural areas. In addition, a defined time line for the production of the focus guide materials would have facilitated this process. Finally, a formal follow-up session was planned but was omitted due to scheduling problems. At this session the content was to be the sharing of the rough draft materials and discussion of common formats. This would have been a major advantage

and might have enhanced the quality of the product. The major weakness if the workshop defined by its participants was that it was not held earlier in the project and that more faculty were not involved.

Workshops - Community

Intent: A series of community workshops, to be offered to professionals, community members and potential students was scheduled for the Spring of 1983. Scheduling difficulties cancelled all but three of the workshops and put two of these off until the summer.

The purpose of these workshops was to provide general community information and to solicit enrollment in the program.

Content and Format: The content and format of the community workshop was a shortened and excerpted form of the faculty workshop. Displays of health promotion materials were available for use as was a computer program in health promotion (developed by the Project Director separately from this project.) Workshop notebooks similar to those provided to the faculty were available as well. One major component of the workshop was to be an evaluation of the intent of the curriculum, as part of the key informant survey described in the section on evaluation.

Results: The first workshop was offered to community health professionals, as well as the general public in the area surrounding the Baptist College. The Participants were invited by formal, personal letter to attend an informal luncheon and three hour workshop. Representatives from local health services, the country health department, the regional Health Systems Agency, community health nurses, and others attended. This

workshop was considered a success by the participants, although a much larger attendance had been desired.

The second workshop was scheduled through a local health education coalition. The format was changed (at the participants' request) to a shorter and more informal session. This workshop was also successful in informing the professional community, but failed to attract any potential students. However, as a result of the pamphlets provided to the participants, a community paraprofessional who was interested in obtaining a relevant degree later enrolled in the program.

The third workshop was scheduled originally through the Clemson Extension Service offices in the western part of the state. Clemson Extension service is the local landgrant College and provides many rural services. One of the services provided is a nutrition program which serves rural populations and employs paraprofessionals. This workshop never occurred, but information was passed on informally, through several extension agents in the field throughout the state and evaluation materials were returned to the project offices.

A fourth workshop was scheduled late in the summer to replace the third. It was scheduled through the St. James Santee Rural Health Clinic. Although participation was minimal, there was extensive return of the evaluation materials, passed on to those who could not attend by those who did. In this sense, the workshop met its minimal goals of informing a segment of the public and providing feedback to the project regarding the intent of the degree.

Strengths and Weaknesses: The major strengths of the workshop was the content of its presentation, the handout materials, and the knowledge base of the providers. However, the weaknesses were far more important than the

strengths, since the major weakness was lack of enrollment and attendance, and this effected the extent to which all the planning was useful. Although the Project Director has reviewed with program consultants the format and intent as well as the method for promoting and enrolling participants in the workshops, no clear source of th weakness could be determined. It was determined that other community workshops in health (one on stress management, another on health promotion) were victims of similar low attendance (the latter was cancelled) with much more aggressive publicity attempts, including paid newspaper advertisements. The timing, at the end of the fiscal year, may have had an impact (even though there was no attendance fee, travel budgets are often depleted by this time of the year) In addition, public health providers had several mandatory state-wide training events at the end of the year, causing administrative difficulties in scheduling people outside of the agency at other times. However, regardless of the possible causes, the major weaknesses seem to be (a) lack of <u>public</u> promotion in newspapers and over the radio, (b) poor scheduling, and (c) poor drawing power of the topic. It is suggested that other locations which attempt to implement this program utilize already scheduled statewide meetings in public health and related disciplines to provide a workshop or present a paper on the project. It is also suggested that informational PR, in the form of overview articles by newspapers and specialized newsletters (e.g. rural electric cooperatives) precede the proposed presentation by several weeks to a month.

Brochures and Information Distribution

<u>Intent:</u> Two types of brochures were developed for

this project. The first was a very early informational brochure on the project, aimed at other sites which might be interested in attempting a similar degree or in receiving information about it. The second brochure was designed to attract student interest and invite enrollment. The distribution mailing lists reflected these two different populations.

Content and Format: Both brochures are included bound in the appendices of this report. The format was similar for both: on salmon-colored stock, a picture of a rural scene (a sun rise behind a barn and other farm buildings); a tri-fold form with two sided copy. The original design was professionally developed and then modified for the second brochure (and for the cover of this project report).

The content of the first (professional) brochure was an overview of the intent of the project, written quite early in the development of the project, which later became somewhat out of date. The content of the student oriented brochure was up-beat, emphasizing the type of activities paraprofessionals in rural health promotion engage in, the newness of the field ("a new day is dawning in community and family health"), and overviewing the components of the degree. The professional contact brochure included a mail back portion; the student brochure included an address and phone number where further information could be gathered.

Several lists were developed and used for distribution of the two brochures. The professional contact brochure was mailed out twice, first to state-wide health settings and to national institutions of higher learning; later to a mailing list which was compiled from contributors to national meetings on rural health held within the last four years. Each time recipients were

asked to respond for further information and were asked to post the information.

The first mailing brought in comments and requests for further information over a period of 10 months. It was through this medium the project obtained its first involvement with the National Rural Health Association and the Rural Health Association of Georgia. In addition, over 30 requests for further information were received and responded to with more detailed curricular information. The second mailing included both the professional and student brochures; it was done in late Spring of 1983 and at this date response is still poor.

The student brochure was also sent to high schools throughout the state, to guidance counselors, to pastors of education in churches, and to a variety of public health settings. Several students have requested enrollment in the program as a result of brochures which they must have obtained through this mailing. However, the response was poor.

Strengths and Weaknesses: The major strength of the brochures has been their eye-catching format and color. The material is accurate and people who respond to it have an excellent idea of what they are inquiring about.

However, the return on the brochures has been poor. It is the feeling of the Project Director and the consultants that a more "slick" presentation of the same material in poster format might receive more attention in the schools. However, a major drawback is the lack of prior existence of this or a similar degree. Guidance counselors have no knowledge of the potential of the field and are not familiar with this type of program because it has never before existed. Reading in the history of nursing shows that similar problems of identity plagued nurses for a long time. The lack of identity, the feeling

that the degree produces a "watered-down nurse" (just as nurses were seen as "watered-down doctors" who had no business providing health care services, even though their training programs often were more comprehensive than were medical degrees of that time) both probably contribute to lack of dissemination by the initial recipients of the material.

It might be useful to produce a document overviewing the types of employment available to paraprofessionals in health promotion - e.g. detoxification centers, halfway houses and other residential settings, outreach workers in health departments, Hospice movements, hot-lines and crisis centers, Department of Agriculture community nutrition aides, community health workers, rural health workers, homemakers (through social service departments), home health aides, etc. However, interviews by the Project Director with the supervisors of many of these positions provided the information that very few if any of these jobs are filled by people who were looking for that type of job. Instead they are filled as a kind of "default" position by drop-outs from nursing and other college programs or by clerical and other support personnel who are being moved up through the system.

This opens up the possibility of providing the Associate Degree in Rural Health Promotion as a form of continuing adult education through one of the more innovative adult education programs. At the Baptist College at Charleston, an evening program for employed adults (the Accelerated Evening Degree Program) already provides a mechanism for those currently employed to return to school without leaving their jobs. Indeed, several inquiries have been received by the Rural Health Project from persons (all women) already employed in the field who are interested in the degree as a form of

continuing education.

Course Development

Choice of Courses: During the development of the curriculum, it became obvious to the two advisory committees that several courses which were necessary for this program were either not in existence at Baptist College or were not focused in the best direction for health promotion. Therefore, development of instructor guides for the following courses became part of the products of the project.

CHEMISTRY - The existing chemistry course was focused primarily on nursing students; it was necessary to re-evaluate the content in light of the requirements of health promotion (as well as considering the courses for which chemistry is a prerequisite, such as physiology).

INTERPERSONAL COMMUNICATIONS - There was no course in inter-personal skills in existence at the Baptist College. Most existing courses at other colleges were focused on therapy or treatment settings. None were at the two year degree level. As part of the Rural Health Promotion Degree, this course was conceived of as a first semester freshman course, preparing the students for on-going consideration of individual concerns and values which might interact with their chosen career path. However, the course needed to have a defined academic content rather than take the form of group therapy or mere awareness training. It also seemed appropriate that this course include a clear focus on cultural differences and their effect on interpersonal communication.

EPIDEMIOLOGY - Epidemiology was determined to be of vital importance to anyone who intended to participate in

public or community health care or health education settings. However, most epidemiology is taught at an upper under-graduate or graduate school level. This course was developed as a conceptual issues course, with general ideas rather than vast amounts of specific data to be memorized.

HEALTH CARE ORGANIZATION AND ISSUES - The need for some formal information on the organization and emerging issues in health care led to the development of a course by this title. The desired content included a general overview of systems and processes of health care, as well as the moral dilemmas of modern health ethics. This course proved to be difficult to find reference materials and resources to facilitate its implementation.

HEALTH PROMOTION SEMINAR - The health promotion seminar was developed to pull together the state-of-the-art techniques of behavior change being used in community health promotion programs. Programs in nutritional modification, smoking cessation, stress management, exercise and physical fitness have become a standard part of offerings in many adult education, community schools programs, through YWCA's etc. These programs often use paraprofessional facilitators; they have a body of specific techniques and cognitive assumptions which form the base for their activities. The Seminar course was also felt to be valuable as a "laboratory" type of experience where students could try out their first prevention/promotion techniques on themselves.

FUNDAMENTALS OF PHYSICAL CARE I & II - Re-named PARAPROFESSIONAL SKILLS I and II as a result of the evaluation, these courses were developed as lecture/laboratory courses to teach specific information and techniques which paraprofessionals can ethically use

in community settings. These courses required extensive revision as a result of the key informant evaluation.

Method of Development: Consultants and faculty members from the Baptist College were recruited in the Spring of 1982 to write the preliminary versions of these seven courses. The flow chart on the following two pages shows the developmental steps that were part of this process from the identification of consultants through the final products which make up the appendices of this report (bound separately). Following the flow chart are individual overviews of the developmental evolution of each course, a summary of the key informant data, and final suggestions.

For more information on the form and content of the evaluation, see Section IV.

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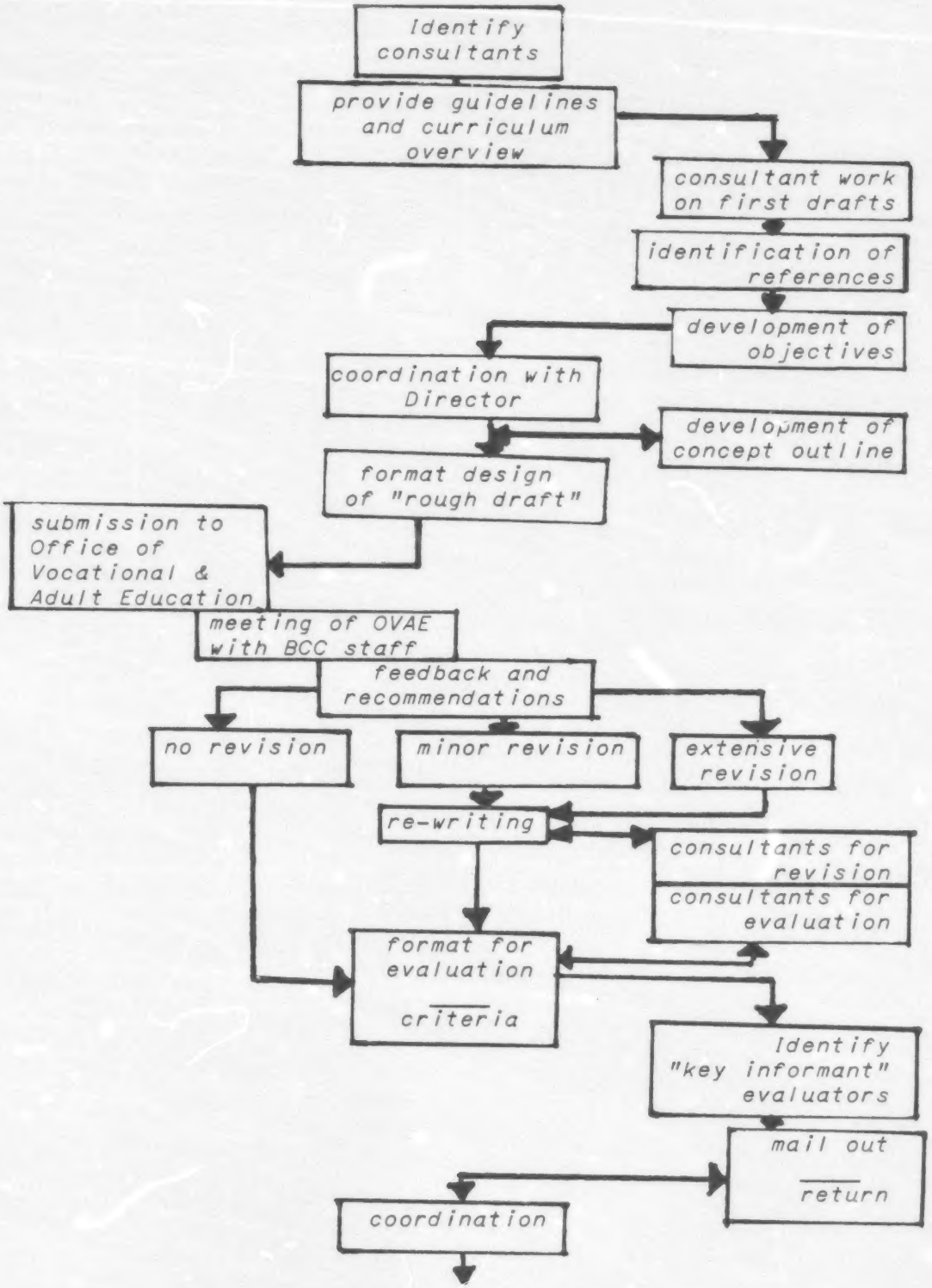
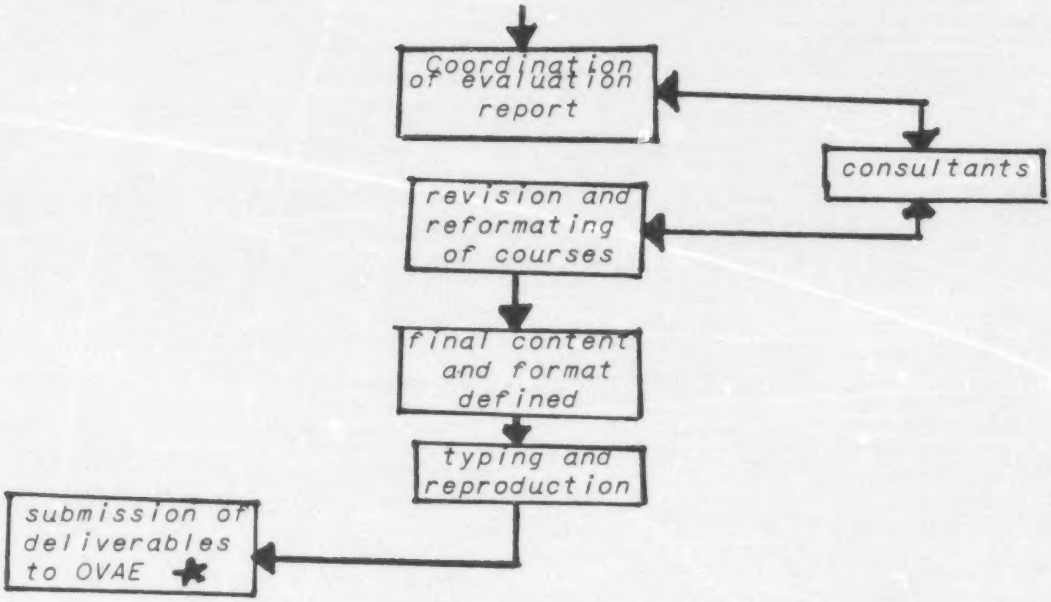
FLOW CHART

FLOW CHART FOR COURSE DEVELOPMENT




Coordination of evaluation report
consultants
revision and reformating of courses
final content and format defined
typing and reproduction
submission of deliverables to OVAE

Development of a Course in
Chemistry for the Life Sciences

For a statement of the rational for inclusion of this course in the curriculum, see the Role of Chemistry in Rural Health Promotion Training in Section V: Appendices of this volume or in the Instructor Guide, a separately bound appendix to this report.

The existing chemistry for life sciences taught at the Baptist College at Charleston had a definite nursing focus. This course was re-written to focus on issues of greater concern to health promotion and health education, as well as to cover the prerequisite information for the biology courses in physiology, microbiology, and nutrition which come later in the curriculum. Laboratories were designed to reinforce basic concepts and to provide an understanding of laboratory techniques, rather than to sharpen skills for later use (since paraprofessionals will need to "know about" more than "know how to do" specific laboratory techniques)

The consultant chosen to write this course was the Chairman of the Chemistry Department at the Baptist College at Charleston. The "rough draft" was approved by the Office of Vocational [illegible]lt Education without revision. The course was taught in two different formats to general students at the Baptist College, which resulted in refining of several laboratory [illegible]essions and making minor changes in the concept outlines. A further recommendation derived from developmental teaching of this course is to avoid teaching it in any compacted form (as in a summer session or inter-term setting); these variations limited the amount of laboratory work which was accomplished as well as reducing coverage of the concept outline. The student feedback on the course indicated no

obvious focus on rural health issues during the presentation, but clear relevance in retrospective analysis. The key informant evaluation had no negative comments.

The final form of the Instructor Resource Guide includes background information on the project and the course as suggested by the Evaluation Consultant. A copy of the table of contents from the guide can be found bound in Section V of this document; the entire course including specific objectives,content outlines, instructor information, texts and references, and evaluation materials is a separately bound appendix to this report.

Development of a Course in Epidemiology

For a statement of the rational for inclusion of this course in the curriculum, see the Role of Epidemiology in Rural Health Promotion Training in Section V: Appendices of this volume or in the Instructor Guide, a separately bound appendix to this report.

Any worker in community health, regardless of specific role, needs to be able to understand the basic concepts of the development of disease and the interaction of host, agent, and environment. Unfortunately, epidemiology is rarely taught as an early undergraduate course, let alone as part of a two year degree. The focus of this course is on general concepts rather than acquisition of large amounts of factual data. It is appropriate not only for this Associate Degree in Rural Health Promotion but for biology students interested in applications of biological principles in this specialized field. It is not a laboratory course.

The consultant chosen to write this course was Assistant Professor of Biology at the Baptist College at Charleston. The "rough draft" was approved by the Office of Vocational and Adult Education without revision. A developmental field testing validated the format and content. Student feedback indicated that while retrospective consideration of the course showed a clear focus on issues of particular relevance to rural health, that focus was not intrusive during the teaching of the course. The key informant evaluation indicated some concern for overlap with previous microbiology courses. This overlap was a conscious attempt to review material for students in a rather intense curriculum and can, obviously, be omitted if redundant for a particular class. An excellent suggestion from key informant evaluation was to spe nd more time on chronic social health problems (e.g. child abuse, infant mortality, malnutrition, stress risk, etc.) in terms of the demographic data and epidemiological principles. Also suggested by the evaluation was consideration of other textbooks - e.g. Grant, Murray. Handbook of Community Health 1981 and Rowche, Barton. Seven Blue Men 1965 (recommended as "fun to read")

The final form of the Instructor Resource Guide includes background information on the project and the course as suggested by the Evaluation Consultant. A copy of the table of contents from the guide can be found bound in Section V of this document; the entire course including specific objectives, instructor information, texts and references, and evaluation materials is a separately bound appendix to this report.

Development of Two Courses in Paraprofessional Skills

For a statement of the rational for the inclusion of these courses in the curriculum, see the Role of Paraprofessional Skills in Rural Health Promotion Training in Section V:Appendices of this volume or in the Instructor Guide, a separately bound appendix to this report.

Initially, when the curriculum was going to have two different tracks (one physical and one mental) this course was titled and intended to teach the physical care skills which might be appropriate and ethical for a paraprofessional in the community. The courses were designed as lecture/laboratory courses with classroom content in disease and disfunction, plus specific information and the laboratory focus on skills such as home health care, first aid, cardiopulmonary resuscitation, and other minor physical-care giving skills.

An external consultant chosen to write this document. The Office of Vocational and Adult Education approved the "rough drafts" without revision. However, the key informant evaluation found serious problems with the courses. Although the courses had already been re-titled Paraprofessional Skills at the recommendation of the Evaluation Consultant, in order to clarify the expectations of the program, there was concern that the role of the graduate was unclear. Nursing instructors and public health educators were uncomfortable with the content of the course as focused by the unit objectives. Further evaluation and consideration of the course as stated proved to reinforce the existance of this problem; the objectives and the content were not clearly paraprofessionally and health promotion oriented.

Revision of the materials was undertaken to clarify these issues, particularly to eliminate any indication that inappropriate skills were to be taught. Re-evaluation of these materials resulted in a clearer understanding of the content and intent of the course Paraprofessional Skills II- "it appears to be a sound course which gives some insight into health problems and the ways to promote health. The content includes information essential for guidance in the area of health promotion." However, the response to Paraprofessional Skills I was still conditional, thought to impinge on the practice of nursing and social work. Based on the laws and expectations in other states, these problems may be serious. Actually, there may well be areas where health promotion impinges on existing professional tasks; just as nursing impinged on the role of the physician when it was first introduced. Today, there is a wide spectrum of opinion in the medical community regarding self-care and other areas of personal responsibility for health. Before implementing Paraprofessional Skills I (which is focused on disfunctions of particular body systems rather than life stages as is II) a college may want to have their own personnel carefully consider the implications of the content and consciously choose a methodology which will avoid the issues of concern.

The final form of the Instructor Resource Guides packaged the two paraprofessional skills courses together, in order to provide the reader with clear comparisons regarding the tone and thrust of I vs. II. This Guide includes background information on the project and the course as suggested by the Evaluation Consultant, the changed form of the objectives and of content in laboratory exercises recommended by the key informant evaluation, content outlines, instructor information,

texts and references (with changes from nursing texts for the laboratory to clearer paraprofessional materials) and evaluation suggestions. The Instructor Resource Guide is separately bound as an appendix to this report. Bound with this report in Section V is a copy of the Table of Contents.

Development of a Course in Health Care Organization and Issues

The statement of the rational for inclusion of this course in the curriculum is found in Section V:Appendices of this volume entitled the Role of Health Care Organization and Issues in Rural Health Promotion. It is also in the Instructor Guide, as separately bound appendix to this report.

This course was developed to give the student in rural health promotion an overview of the systems which provide and support health care in the United States as well as the issues of current concern ethically. As it was developed it became obvious that the content of this course would be quite broad, even though provided in a summary manner. Outside consultants will be very useful in the teaching of this course. An introduction to use of computer systems is a brief but important segment of the course.

The course was written by the first Program Director. It was accepted in "rough draft" form by the Office of Vocational and Adult Education, with minor changes. The key informant evaluation rated the content as highly useful to health promotion and was concerned only that there was no text or reference which could provide the students with a written up-to-date version of the content.

The evaluation suggested strong reliance on outside experts in the areas of insurance, health planning, and third party reimbursement, which seems very appropriate. Several suggestions made during the evaluation for good activities and exercises were included in the revised version of these materials.

The final form of the Instructor Resource Guide includes background information on the project and the course as suggested by the Evaluation Consultant. A copy of the table of contents in found bound in Section V of this document. The entire course including objectives, content outlines, instructor information, texts and references, and evaluation suggestions is a separately bound appendix to this report.

Development of a Course in Interpersonal Communications - Technique and Style

For a statement of the rational for the inclusion of this course in the curriculum, see the Role of Interpersonal Communication in Rural Health Promotion Training in Section V:Appendices of this volume,or in the Instructor Guide, a separately bound appendix to this report.

The intent of this course was to teach students to use basic interpersonal communication skills, to be able to evaluate their own abilities and barriers and to be able to accurately interpret others. The "rough draft" of the course, written by an outside consultant with a counseling orientation, was rejected by the Office of Vocational and Adult Education as too therapeutically, group experience oriented with insufficient content for an academic course. The second Project Director, having had

experience in communications skills from an educational rather than therapeutic orientation undertook to rewrite and teach a developmental version of this course. One other ccriticism of the first version of the course was that it was too dependent upon one particular book's terminology. This became obvious when it was discovered that the book recommended by the first author was out of print. The revision used four different books as references in order to extract common approaches and general language that was used by a variety of authors. While experiential components had to be included in the course in order to teach the skills required, a clear definition was given of the differences between this type of educational setting and any counseling environment.

The key informant evaluation identified this new version of the course as appropriate to the goals of the curriculum and the content as "thoughtfully selected and relevant" to health promotion. In addition, the comment "the thread of culture is very nicely evident throughout" indicates successful inclusion of this important material. The student feedback indicated that retrospective analysis of the course clearly evidenced its orientation to health, but that this focus was in no way obvious during the course itself.

The final form of the Instructor Resource Guide includes background information on the project and the course as suggested by the Evaluation Consultant. A copy of the Table of Contents from the guide can be found bound in Section V of this document. The entire course is separately bound as an appendix to this report, including the objectives, content outlines, instructor information, texts and recommended references, student handouts, and evaluation materials.

Development of a Course in
Health Promotion Seminar

The statement of the rational for inclusion of this course in the curriculum in found in Section V:Appendices of this volume under the title Role of Health Promotion Seminar in Rural Health Promotion Training. It is alsopart of the Instructor Guide, a separately bound appendix to this report.

The intent of this course was to introduce some of the techniques of health promotion through behavior change in an experiential format, so that students can learn from personal experience the difficulties of specific behavior change. The "rough draft" version of this course was written by the second Project Director prior to being hired to direct the project. The Office of Vocational and Adult Education accepted the general intent of the rough draft version but requested additional information and modifications in the format. This was done prior to the developmental teaching of this component. The student feedback indicated that the rural orientation of the degree was not obvious during the course but that the material was highly relevant. The key informant evaluation of the revised version was in strong agreement with the appropriateness of the material and its level. Specifically emphasized was the usefulness of the focus on change and resistance to change in different settings. No changes were suggested, although several alternative texts were mentioned.

The final form of the Instructor Resource Guide includes background information on the project and the course as suggested by the Evaluation Consultant. A copy of the table of contents from the guide can be found bound

in Section V of this document; the entire course including objectives, content outlines, instructor information, texts and recommended references, and student evaluation materials is a separately bound appendix to this report.

SECTION IV
EVALUATION DEVELOPMENT

EVALUATION DEVELOPMENT

Intent of Final Evaluation

Educational evaluation can take a number of forms. It may be part of a true experimental design - with random assignment, control groups, and sophisticated statistical analysis. However, it may also be the attempt to determine the efficacy of appropriateness of some educational approach in a less scientific settings. Regardless of the type of evaluation chosen, the first step in the design is the definition of intended benefits or desired outcomes of the program. Having defined these ideal outcomes, it is possible to compile data and reach a judgment about the success of the program.

There were essentially two levels of desired outcomes in the revised project activities -

(1) the design of a two year curriculum to train paraprofessionals for the promotion of health in rural areas.

(2) the development of courses and adjunct materials which would be needed to implement the program

The evaluation becomes one of process and product but not of impact. Rather than testing the ultimate learning of participants in the program, we test the appropriateness of the goal and the perceived efficacy of the materials in reaching this goal.

In designing a process evaluation there are a number of methodologies which can be utilized. Green, Dreuter, Reeds and Partridge in Health Education Planning, 1980 list as possible methods "government surveillance of contracts and grants;" thus the ultimate production of the

deliverables in a project constitute one primary evaluation of the project's intended outcomes. Another method listed in process evaluation is "peer review" or "key informant data."

Scope of Evaluation: The two aspects of the project which can be evaluated without a true experimental design are -

1. evaluation of course content
   a. Do the courses represent content deemed by professionals in health education to be appropriate in scope and depth for the production of graduates with the desired knowledge, skills, and attitudes?
   b. Are the intended outcomes for the students, as represented by the objectives, appropriate in specificity and importance to the current state-of-the-art in each field of study?

2. evaluation of total program design/intent
   a. Does the curriculum include content which is seen by people living and working in rural areas as important or useful in their communities?
   b. Are the skills, knowledge, and attitudes expected of program graduates seen as important by employers of paraprofessionals?

Process of the Evaluation: The following procedures were used to answer the evaluation questions posed above.

1. evaluation of course content
   a. a minimum of two peer professionals or "key informants" were identified for each of the newly designed courses
   b. given an overview of the course materials and

a summary of the project, they completed a detailed "professional evaluation form" (see Appendices)

2. evaluation of total program design
   a. a selection of community members and possible employers was selected from around the state (using the community workshops as a contact vehicle)
   b. given a list of 20 areas of knowledge, 10 skills areas, and 4 areas of experience, the "key informants" indicated which would be helpful in their community (or job) to help people "live healthier lives, take charge of their own health, and make better decisions about their style of life."
   c. given six statements indicating the extent to which a person so trained would be useful, the "key informants" indicated the level of their agreement or disagreement.

Results of the Evaluation

Qualitative Interpretation of Data Gathered: The information gathered from these "key informants" and the trends seen are summarized below. Copies of the evaluation and feedback forms will be found in the Appendices in compacted form(without the open layout which facilitated the answering of the questions).

Courses: In general, all courses except for the Paraprofessional Skills I course received very positive evaluations. Respondents to the questionnaire "agreed or strongly agreed" with queries about appropriateness and utility of title, content, prerequisites, objectives,references.

There were several courses where additional books were suggested as more current, but no books were found to be inappropriate (except in Paraprofessional Skills I). No material was ever defined as extraneous or appropriate for elimination.(except in PP Skills I)

In addition to the questionnnaire data, there were several comments about the clear definition of the task. The Evaluation Consultant discussed the process of evaluation with the professionals after the evaluation had been completed. Estimates of 4 to 6 hours were not uncommon for the time which had been taken to explore the materials and answer the questions. Several evaluators explored alternative references or checked ours in the library.

Looking more closely at the negative evaluation of the Paraprofessional Skills I course - the Evaluation Consultant expressed similar views of the activities which seemed to be implicit in the objectives and content outlines. The concern was that nursing skills and diagnostic tasks were being taught to people who would never be able to use them (ethically or legally).

Several examples of this problem and the revised objectives are noted below. The language which was creating the major discomfort is underlined.

1.ORIGINAL LANGUAGE

> After completion of this unit (IX) the student will have knowledge of the blood's function and structure, the component parts of blood, the pathophysiology of shock, and related patient care needs. The student will be able to interpret results from diagnostic tests and to apply this information when administering care to an individual or family in the community.

1. REVISED LANGUAGE

After completion of this unit the student will have knowledge of the blood's function and structure, the component parts of blood, the pathopysiology of shock, and related patient care needs and will be able to work in an educational or supportive manner with a health care team.

2 ORIGINAL LANGUAGE

The student after completing this unit will be able to administer health care to an individual who has an infectious or non-infectious skin lesion or a serious burn. They will be able to assist the individual or family to manage their skin disorder in the home setting ultimately to recover their optimal potential.

2 REVISED LANGUAGE

The student, after completing this unit, will be knowledgable about the health care needs of an individual who has an infectious or non-infectious skin lesion or a serious burn and will be able to work with the individual or family in an educational or supportive manner to recover their optimal potential.

One evaluator presented a practical nursing curriculum which covered similar areas to the original language. Another asked the question "Is the graduate of the program to be an independent practioner who will be making judgments and decisions?...It is not clear how the individual will know when to act and when not to act.." The revised objectives seem to clarify the role which is expected of the paraprofessional and have tried to eliminate all terms which imply patient care or the application of personal knowledge to advising particular treatment regimes independently of a professional supervisor.

A more far reaching comment was, "I believe there are some legal questions as to the content objectives impinging on the practice of nursing and social work." While discomfort with treatment being provided by unsupervised paraprofessionals is understandable, this comment seems to go beyond use to knowledge ("content" rather than "behavioral") It is not clear that there are any legal restrictions on what content people can learn about how their bodies function. However, regardless of the reasonableness of the idea of it being illegal to cover certain content, it certainly is possible for certain tasks to be illegal to preform. If the course in anyway prepares people to act in illegal ways, that content needs to be eliminated. The Project Director and Evaluation Consultant worked to restate this course to eliminate any problem areas.

Program intent: Both professional and community members in a variety of sites rated the basic knowledge, skill, and experience areas as overwhelmingly VERY IMPORTANT. (21 completed evaluations were returned) Area which received any less positive ratings at all were "emotional support" - rated not useful by one person the core sciences of microbiology and chemistry - rated moderately useful by about one fifth of the raters, the New Testament - rated moderately useful by about one fifth of the raters.

One of the professionals who hires paraprofessionals to provide nutrition "education/counseling" rated about half of the items as very useful and the others as somewhat useful. No other rater gave more than 3 ratings lower than very useful.

In the areas of "how a person with the skills, knowledge, and experiences could help my community," the only area where any disagreement was indicated was in

"could do things that doctors, nurses, and social workers don't have time to do" (by two raters) and "could be used by our church to help the community."(by one rater)

In other words, the overall feedback from community members and potential employers was that the intent of the program was desirable and would produce positive impact on their community. Even the least strongly positive professional rater indicated a strong interest in hiring graduates of the program and was disappointed to find that such persons would not be available this year.

Incidential Data: A further qualitative evaluation factor was obtained while conversing with professionals who hire and supervise paraprofessionals (in detoxification centers, residential programs for unwed mothers, agricultural extension agents, and in nutrition outreach). In describing their need the following general characteristics were common -

the role of the (paraprofessional) is to

* provide limited support to health professionals, particularly with the area of vital signs (temperature, blood pressure, heart rates)
* provide education (in health related areas)
* be aware of community resources and encourage families to utilize appropriate ores
* provide individual and group learning experiences
* adapt methods and content to meet the needs interests and abilities of each family member
* determine needs and "felt" interests, by listening and questioning
* attempt to guide the family members into action which meets their needs

* maintain records of their own activities and behavior of others
* provide education to youth
* contribute to the personal development of disadvantaged people
* makes referrals
* gives oral reports

One paraprofessional position which includes nearly all of the above characteristics has existed in large numbers throughout the country for the last 17 years, funded by Federal support. The position is defined by one supervisor as "hard to fill" because "the pay scale is too low for a BS level graduate, and those without degrees willing to work often don't have the right preparation."

The supervisor prefers not to hire at the BS level because the paraprofessionals tend to "stay longer and be more patient with the families." Yet there are increasing problems, with health information of dubious quality being published in the print media, applicants for the position not only are un-educated but "know" things which are erroneous.

Another supervisor of paraprofessionals at a residential setting felt that all of the above characterisitics would be valuable for her employees, but noted that usually she has to "take what she can get," and that she is lucky if the positions are filled by people who "care."

The result of these comments is an affirmation of the appropriateness of the curriculum content and the need for the graduates of the program in community settings.

SUMMARY

Contract No. 300-81-0436 has successfully produced a 66 credit Associate Degree in Rural Health Promotion which has been evaluated by community members and health care professionals as designed to produce a graduate who would help people

*** live healthier lives,

*** take charge of their own health, and

*** make better decisions about their style of life.

The potential graduates of this program were perceived to have the capacity to

*** "help me and my family live a healthier life,"

*** "be a good resource for our local schools,"

*** "provide support to families in our community,"

*** "do (limited) things that doctors, nurses, and social workers don't have time to do,"

*** "be useful in existing medical and social services," and

*** "be useful to our church in helping our community."

Professionals who work with and hire paraprofessionals under a variety of titles identified the proposed graduates of the program as desirable.

As part of the project, seven new courses were developed. Professional peer evaluations judged the content and focus of these courses (with the exception of one course with significant overlap with practical nursing skills) to be appropriate and useful. The problem course was revised prior to this report, based on suggestions by the Evaluation Consultant. In addition, ten other professionals produced materials to coordinate the intent and content of theses specialized courses with the core courses which constitute the rest of the curriculum.

The program as designed in this project has been included in the course offerings of the Baptist College at Charleston beginning in the Fall of 1983 and has 4 students enrolled as majors in the Associate Degree (which is still in its introductory stages). Requests have come from 30+ other sites and professionals nationally for further information, including state Rural Health Associations.

To quote from Andrew C. Twaddle and Richard M. Hessler, authors of A Sociology of Health -

> "...the seed has been planted for changes in health manpower. If health care is to be made available to all as a right on the order of public education, then change must occur ..."

and from Frank Riessman, in introducing The Nonprofessional Revolution in Mental Health, by Francine Sobey -

> "Nonprofessionals are utilized not simply because professional manpower is unavailable but rather to provide new services in innovative ways"

and from the 1979 U.S. Surgeon General's Report on Health Promotion and Disease Prevention Healthy People

> "Let us be clear about one fundamental fact: the changes required, if we are to mount a successful public health revolution in the next generation, go far beyond the traditional health care community."

SECTION V
APPENDICES

BROCHURES

Place Stamp Here

Susan W. Wallace, Project Director
Baptist College at Charleston
Natural Science Division
P.O. Box 10087
Charleston, SC 29411

95

Rural Health Project

A
HEALTH
PROMOTION
PROJECT

Baptist College at Charleston
Charleston, South Carolina

PARAPROFESSIONAL RURALLY ORIENTED FAMILY, HOME HEALTH TRAINING PROGRAM

93

96

A Project of National Significance for
the U.S. Department of Education
Office of Vocational & Adult Education
Contract No. 300-81-0436

ASSESSMENT OF NEED

One of the most profound challenges facing the nation today is reform within our health care system to insure that rural Americans have access to regular, effective and affordable health care.

The need is more apparent when we recognize that almost one-third of the nation's population live in rural areas. However, only about 20 percent of the health care professionals are available to serve that population who statistically have a poorer health status than urban residents.

In order to improve accessibility more paraprofessionals need to be trained to reach out to these rural individuals and supply them with minor physical care as well as education to promote individual responsibility.

BASIC OBJECTIVES OF PROJECT

1. To design a training program which would enable an individual to engage in home health service delivery at the paraprofessional level.
2. To implement a pilot training program.
3. To evaluate the program materials.
4. To evaluate the effectiveness of the preparatory program.
5. To make program materials available to other colleges and universities.

EXPECTED BENEFITS

1. Provide a new service to rural communities which is essential to improved quality of life and economic development.

2. Improve health services by creating jobs and generating income for rural communities.

3. Assure rural people the same access to health services that others throughout the nation enjoy.

4. Lessen the impact of illness by increased awareness of disease prevention.

RURAL HEALTH CARE

CONTRACTOR:

Baptist College at Charleston
Susan W. Wallace, Project Director
Division of Natural Sciences
P.O. Box 10087
Charleston, South Carolina 29411

Phone: (803) 797-4203

Project Duration:
1 October, 1981
30 September, 1983

INFORMATION

If you wish to receive further information about the project, please complete this form and return it to Susan W. Wallace, R.N., M.P.H., Director, or telephone (803) 797-4203

ORGANIZATION

Name

Position

Address

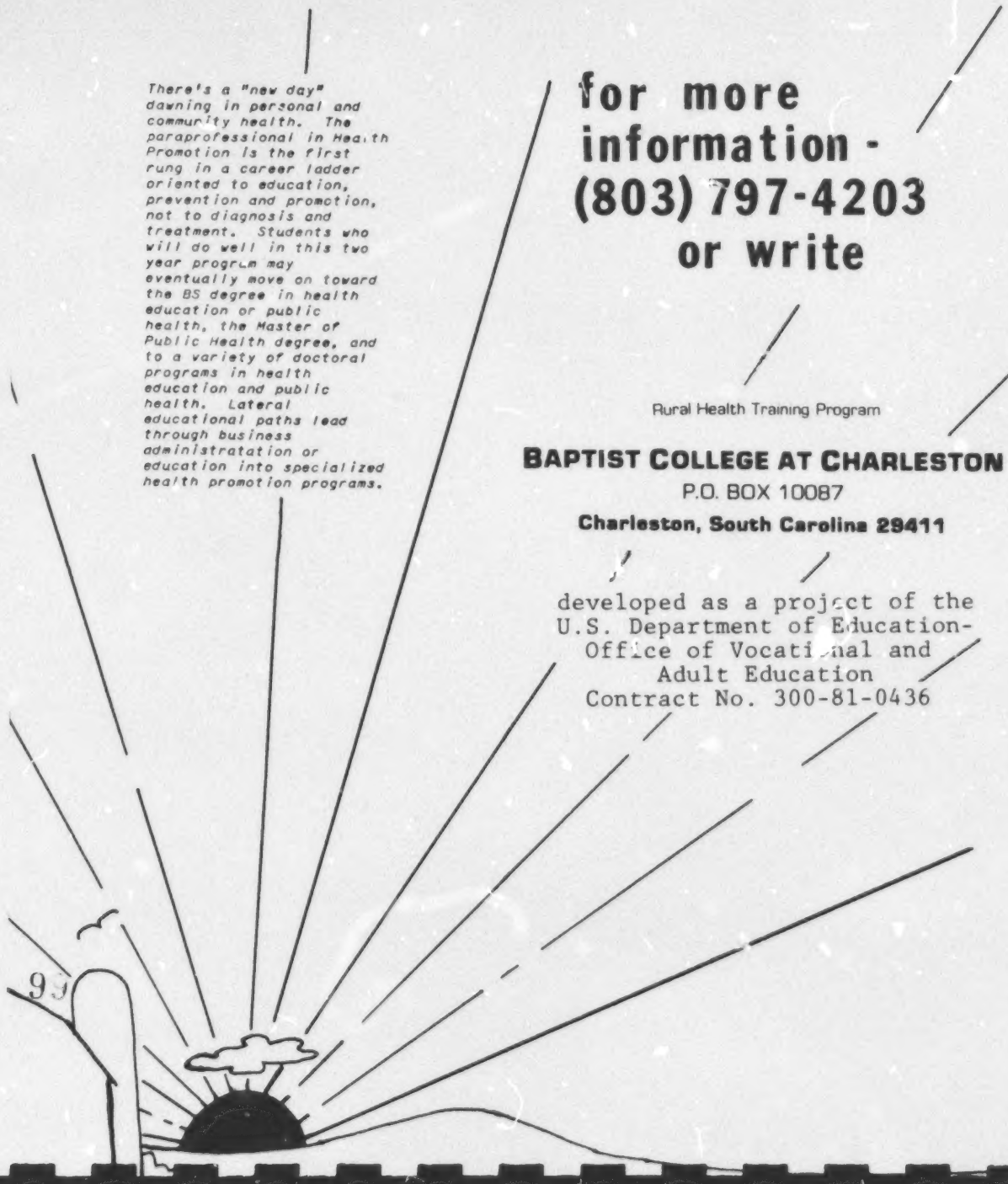
City

State Zip

- ☐ Please add me to your mailing list.
- ☐ I have information to share.
- ☐ I may be interested in adopting a program like this for my organization.

Comments:

There's a "new day" dawning in personal and community health. The paraprofessional in Health Promotion is the first rung in a career ladder oriented to education, prevention and promotion, not to diagnosis and treatment. Students who will do well in this two year program may eventually move on toward the BS degree in health education or public health, the Master of Public Health degree, and to a variety of doctoral programs in health education and public health. Lateral educational paths lead through business administratation or education into specialized health promotion programs.



for more information - (803) 797-4203 or write

Rural Health Training Program

BAPTIST COLLEGE AT CHARLESTON
P.O. BOX 10087
Charleston, South Carolina 29411

developed as a project of the U.S. Department of Education-Office of Vocational and Adult Education
Contract No. 300-81-0436

Rural Health PROMOTION

a two year program of study in disease prevention and health promotion

95

" a NEW DAY in personal and community health "

Baptist College at Charleston-

100

Why "HEALTH PROMOTION"?

"...further expansion of the Nation's health care system would produce 'only marginal increases in the overall health status of the American people.' In the long run...the greatest benefits are likely to accrue from efforts to improve the health habits of all Americans and the environment in which they live and work."

page 425
1979- US Surgeon General's Report
- Healthy People

THE HEALTH PROMOTION PRACTITIONER-

USING THEIR TRAINING TO HELP
THEIR COMMUNITY
THEIR NEIGHBORS
THEIR FAMILIES
THEMSELVES.

THE CURRICULUM

This is a two year, 66 credit progam. The first year, and much of the second year, are basic components of any Bachelor's degree at BCC:

48 credits in basic studies-
- * in communication skills: English and interpersonal communication
- * in religion and sociology
- * in the natural sciences: biology, chemistry, math, psychology

18 credits in specialized studies-
- * health care systems and issues
- * health promotion
- * nutrition
- * health care basics
- * directed work experience

THE HEALTH PROMOTION PRACTITIONER-

- * caring about people and the community
- * sharing information, support, skills
- * communicating with individuals and families about
  - health risks
  - health services
  - responsibility
  - optimal health
- * supporting individuals and families as they learn new ideas and skills for-
  - coping with chronic and acute illness
  - changing health behaviors
  - making better health decisions

Working in support jobs promoting health and preventing disease in...
- * health departments
- * drug and alcohol programs
- * mental health systems
- * residential care
- * hot lines
- * rural clinics

Applying special skills to improve the health of their communities while holding jobs in...
- * school systems
- * churches
- * social services
- * business and industry
- * public office

USING THEIR TRAINING TO HELP
THEIR COMMUNITY
THEIR NEIGHBORS
THEIR FAMILIES
THEMSELVES.

EXCERPTED COURSE MATERIALS

Instructor Resource Guides
for these courses
are
bound separately

The Role of
CHEMISTRY FOR THE LIFE SCIENCES
in Rural Health Promotion Training

The entire inner status of the human organism, indeed every interaction the human makes with the outside world, is chemically mediated. From the thought processes themselves to muscle action, from digestion to the immune response, from the body's allergic reactions to the world to the impact we make on the world through technology - chemistry is the language that is used to describe life. The health promotion paraprofessional needs a good grasp of basic chemistry to be able to have a realistic and credible view of the "raw material" of health promotion and of the end "goals."

Chemistry undergirds any in-depth understnading of the academic and applied subjects which are of direct importance to the tasks of health promotion. Physiology, nutrition, microbiology, epidemiology, as well as the methods and means to prevent, intervene in, and treat diseases all are important when dealing with a person's life style and its impact on his health.

Just as important, an understanding of chemistry allows for informed consumer evaluation and choices - from health advertising "gimmicks" (don't put chemicals in your body!) to informed use of medical care. Not only does the paraprofessional need chemistry to explain that if we didn't eat "chemicals" we would never eat at all, the paraprofessional needs chemistry to explain the importance of trace elements, "balanced diet", and the importance of therapeutic drugs and regimes.

While a single introductory chemistry course does not prepare anyone to do even simple biochemistry or drug pharacology, it does prepare the student to understand

(and pass on that understanding) of the specificity of chemical interactions, where ever and why ever they occur.

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The Role of EPIDEMIOLOGY in the Rural Health Promotion Curriculum

Epidemiology is the study of the inter-relationships among organisms, the environment and man. It includes the natural history of disease as well as signs, symptoms, and issues of prevention. In the field of community health, epidemiological data identifies areas of immediate concern, tracks the effects of sociological and biological changes on the health of a population, and helps to define future tasks and directions. Health promotion is also affected by the dynamic interplay of host, environmental setting, and causitive agent factors. The so-called "diseases of life style" often reflect both subtle and gross changes in the balance of these factors.

In addition, epidemiology utilizes experimental design, data gathering and data assessment as well as the compilation of demographic information. These are vital techniques for health promotion in defining the "need" for community and family programming as well as studying the impact of the educational, preventative, and interventative approaches which make up health promotion. Even if a paraprofessional does no evaluation or research themselves, they need to be able to understand the important characteristics of such data when they encounter it in written form or in health planning settings.

The health promotion paraprofessional will need to interact with public health workers and, although less effected by changes in causitive agent dynamics, will nonetheless need to be aware of acute situations in the community or target group where they work. An understanding of the realities of public health practice

will be vital to dealing with professionals in health administration or treatment positions. A thorough grounding in the epidemiological factors of disease will be valuable to the health promotion paraprofessional as they work with other members of the community and family health care team and will make them more effective as they provide support and referral services to individuals and families.

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THE ROLE OF
HEALTH CARE ORGANIZATION AND ISSUES
IN THE RURAL HEALTH PROMOTION CURRICULUM

Health promotion activities are part of the goals and objectives of many community health care providers and occur in many different health care settings. Health promotion paraprofessionals may be providing services at a "primary" level, working before the fact with people of low or moderate current risk to prevent development of health problems. Often, however, the provider of health promotion will be working in "secondary" or "tertiary" settings, where participants have clearly developed risks, are already experiencing some difficulty, or have gone through some acute episode or health crisis. In these cases, health promotion may become part of a treatment plan developed and monitored by professionals from a variety of fields--medicine, rehabilitation, psychology, and others.

The health promotion paraprofessional may also, by virtue of their activities in a community, be in a position to interact with public and private health care treatment as a referral or support person. It is vitally important that the paraprofessional understand the systems with which he or she may be working and be able to relate to the realities of purpose and practice of these settings.

The course in health care organization and issues will give students a chance to explore the function and administration of community health care services both public and private. Students will consider in detail some of the issues impacting current and future direction in treatment services. These include issues affecting health care utilization and delivery as well as ethical issues relating to consumerism, self care, death and dying, and the impact of modern technology both in treatment and administration.

Included in this course are sections on changes affecting health care utilization and delivery, the impact of modern technology on treatment, administration, and education, as well as current ethical issues in health care such as consumerism, the self care movement, death and dying, and others.

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The Role of HEALTH PROMOTION SEMINAR
in the Rural Health Promotion Curriculum

The last part of this century has seen a significant shift in U.S. patterns of mortality and morbidity. Today, over 75% of all deaths result from illnesses or conditions clearly related, at least in part, to life style. While improvements in health and life span in the first half of the twentieth century have resulted primarily from improved treatment and prevention of infectious diseases, the next "revolution" which will enhance the quality of health is expected to come from the promotion of healthier life styles - with a focus on the individual and those factors which influence the chosen behaviors of the individual.

The synergistic interaction of life-style elements means that health promotion efforts cut across and link apparently diverse areas of illness. The major death and disability issues share many common causes and interactive exacerbating factors:

* exercise
* concern over what we put into our body in the form of foods, alcohol, and other drugs
* living in high stress environments

The 1979 U.S. Surgeon General's report on Healthy People identifies these common causes as risk factors to be trageted in the 1980's. These same factors transcend the variety of settings which help to shape the attitudes and actions of individuals - settings including the work place, the family, the schools, the society as a whole.

Thus the health promotion paraprofessional will also need to be able to put together knowledge of a variety of academic areas with skills in the facilitation of behavior change.

The Rural Health Promotion Associate Degree program provides the student with many foundation courses from which the issues and skills of health promotion are drawn - biology, psychology, written and oral communication, paraprofessional skills. However, actual behavior change has been shown to depend very little on knowledge of general risk and very much on the dynamics of personal values, needs, and beliefs. Nonetheless, it is the tendency of both paraprofessionals and professionals alike to use factual material as their primary way of motivating others to change. The inappropriate use of scare tactics in prevention and promotion programs is an occupational hazard in health care. The Health Promotion Seminar is designed to counteract these tendencies by giving future health promotion paraprofessionals a personal experience in making positive changes in their own health habits. Since each class member will have an opportunity to analyze their own health status in a variety of areas and then to plan and implement personal interventions, the seminar provides a setting where the difficulty of making life-style changes can be discussed in a personalized manner. By giving specific attention to sources and types of success and failure, the course takes textbook level theory and shows its action in the real world.

The task of the seminar is one of taking cognitive information and personalizing it, thereby helping the students to internalize the problems of health promotion. Information and skills from the entire curriculum are used to discuss the origin, theory and application of techniques in community health promotion. Current issues

of health promotion will be discussed, common responses and approaches to health promotion in a variety of areas will be introduced and techniques of facilitation will be presented. Drawing from the background of the students in the class and from current lay interests, the seminar will involve participants in analysis and comparison of professional and lay literature in a variety of areas.

The role of this "laboratory" experience in health promotion is, like most laboratory courses, one of transition and internalization of knowledge and the development of skill. Transition from "book learning " to the "every day world" is important in avoiding disillusionment and frustration for the health promotion paraprofessional on the job. Such personal experiences with the ideas of the curriculum allows for understanding of the experiences of others and the difficulties they have in making changes to healthier life styles. Personal experiences in failure to change, backed up by open and understanding discussion of those experiences, helps the practicing health promotion facilitator to avoid counterproductive use of factual knowledge and trite and idealized advice when trying to help others learn to change.

The course does not aim to teach the planning skills or even provide comprehensive training in very many techniques of prevention and promotion. The role of the paraprofessional is not an administrative one; rather it prepares the student for later learning in a variety of areas by illustrating for them the common element in the many fields of health promotion - the common element of human resistance to change.

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The Role of

INTERPERSONAL COMMUNICATION: TECHNIQUES AND STYLE

in the Rural Health Promotion Curriculum

Health promotion depends extensively upon communication skills, both written and oral. Most actual health promotion occurs in small group or person to person settings, where people can explore ways to change behaviors and life styles based on information provided by professional sources and systems. For effective promotion of positive health changes, even information must be personalized and integrated into the personal and cultural context of the individual.

Interpersonal skills include not only the ability to originate and respond to verbal messages, but also the interpretive techniques which draw upon non-verbal cues and cultural style. Rural areas today consist of a variety od different cultural realities and the paraprofessional must learn how to be effect and accurate in communicating with others who are different from themselves.

In addition, the health paraprofessional needs to be able to learn from and provide information to people with a wide variety of health care and health related backgrounds. Formal knowledge of theories of communication can provide patterns to analyze unfamiliar styles and also can promote discussion with professional support systems. Thus, the position of paraprofessiional - between the professional and formal service providers and the informal lay community - requires sophisticated communication and listening skills for use with those more and less knowledgible than self.

The ability of a paraprofessional to help facilitate

health promotion behaviors in others must be built upon the experiences of the facilitator in personal awareness, evaluation and change. The course in interpersonal communication begins this process, for before the student can make personal health habit changes, they must have explored their own context and style. Indeed, for effective use of many of the later courses in the curriculum (such as health promotion seminar and the paraprofessional skills courses) as well as for gaining the most from the off-campus practicum experience, the student must be able to analyze their own and others responses, explore the possible role of contexts and hypothesize intent of communication, apply skills in listening and responding which act to open up lines of communication and clarify both information flow and interpersonal expectations. The student will need to be able to see possible adadaptations of both style and skill to varied situations and settings in order to enhance the likihood of positive outcomes for all.

The content and skills of the interpersonal communication course will be supported and reinforced throughout the rest of the program. Personal context and motivation will be explored through studies in psychology; dynamics of small and large groups and the cultural contexts of human relations will be taught in group dynamics, religion, and sociology courses,; verbal communication skills will be polished in English composition and rhetoric; and the special courses in health care issues and paraprofessional skills will take the previous learnings and explore them in health care settings.

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THE ROLE OF
FUNDAMENTALS OF PARAPROFESSIONAL CARE
IN THE RURAL HEALTH PROMOTION CURRICULUM

Although it has been uncommon to train paraprofessionals in health promotion through a college degree, paraprofessionals have been used in health settings for many years. There are many community programs which teach skills and information in health which can be applied on a paraprofessional level. The two lecture/laboratory courses in paraprofessional care draw from existing training for community paraprofessional to teach a broad spectrum of useful knowledge and skills in a coherent manner. While previous courses in biology and psychology allow for a more sophisticated treatment of some of the subjects than might be common in a community volunteer settings, the skills are still those of a paraprofessional. These courses will pull together data about common health problems and situations and will prepare the paraprofessional to be an informed member of their community and family and to work with a variety of health care systems.

The skills of paraprofessionals commonly used in communities include physical care (in home health settings), psychological support (in Help Centers and Hotlines), personal hygiene (with youth groups and the elderly), safety and first aid (on job settings and as a concerned citizen). The necessary knowledge includes understanding the development, prevention, intervention, and treatment of common community and personal health problems - more often at a chronic than at an acute level.

This broad spectrum of abilities, from being able to take blood pressure readings and apply basic first aid, through emergency first aid such as Cardiopulmonary resuscitation, and including the ability to listen to people's problems and to help them develop an understanding of them (at a reflective, not therapeutic, level) are commonly used in communities in hospitals and nursing homes, in home health support services, in halfway houses and other supportive residential settings such as Hospice, detoxification units, and shelters. The paraprofessional care course will teach these and

other skills in an integrated and coherent manner, linking techniques and knowledge in the paraprofessional area to academic content of the rest of the program and preparing the student for actual work in the health promotion practicum.

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THE ROLE OF CORE COURSES IN RURAL HEALTH PROMOTION TRAINING

Modern concepts of health, as they relate to both public education and health care provision, are holistic in nature. This implies specific educational needs to prepare both professional and paraprofessional service providers regardless of where they fall on the health services continuum -prom primary prevention (i.e. health promotion) to tertiary prevention (i.e. treatment of disease and patient maintenance). Today's health services provider is dealing with a concept of human health which embodies biological, psychological and spiritual aspects. The education of the health promotion paraprofessional must therefore include training:

1. in the cognitive concepts relating to the biological and biochemical functioning of the body
2. in the theory and application of psychological constructs
3. in the inter-relationship of these two academic areas dealing with mind and body
4. in the contextual areas of religion and sociology
5. in the practical application of basic skills in English, mathematics, and oral communication

This set of knowledge and skills can then be used in both the learning and application of health promotion techniques through specialized courses.

Since the Associate Degree in Rural Health Promotion has been designed around a core of commonly occurring academic offerings, the degree can easily be added to both two and four year institutions by adding only the specialized courses relating to health promotion concepts, skills, and

applications. This academic core allows students to move on to a four yea degree if they so desire; it also allows the college to adapt the health promotion courses as a minor in existing four year degrees.

However, for those students for whom the Associate Degree is their goal (interim or ultimate) there is concern that the broad academic core might appear to have limited immediate or specific relevance. Rather than approach relevance through specialized courses (e.g. "English for the Health Promotion Student") - which might limit not only the immediate learning but also the future mobility academically - we have chosen to write a series of <u>focus</u> guides. These guides discuss the issue of relevance in both general and specific terms, suggesting special topics, projects, and instructional mechanisms which can be used to enhance the learning of the rural health promotion student (and, indeed, the entire class) without damaging the integrity or general impact of core courses on the academic goals of the entire institution.

The Focus Guides leave course concept outlines and objectives intact, making suggestions not so much in content or methodology but rather in instructional "accent.". Each Focus Guide highlights those topics within the normal structure of the course which are of particular relevance to rural health and which can be used for home work, for special projects, for classroom examples and discussion and for test questions.

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by Silas H. Garrison, Ph.D. and Carol Jean Drowota, Ph.D.

Group Dynamics 43
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Psychology:
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Adult Development and Aging 65
by George Connor, M.S. and
Tom Gorry, Ph.D.

Sociology (Introductory) 73
by Graham Tomlinson, Ph.D.

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EVALUATION FORMS

SAMPLE PROFESSIONAL EVALUATION
-Course Content-

EVALUATION FORM - NEW COURSES
RURAL HEALTH PROMOTION CURRICULUM

Thank you for agreeing to help us to evaluate our new course on
You should find the following materials attached to this form.

a) overview materials introducing the Rural Health Promotion currivulum
b) selections from the newly developed course
c) a self-addressed stamped envelope, eith your name and return address on it, and an envelope with the course name on it.

Please follow this procedure in providing us with evaluation information:

1. read the overview materials introducing the Rural Health Promotion Associate Degree
2. read (but do not fill out) the questions about the new course
3. read the selections fromt the new course
4. answer the evaluation questions and make any additional comments
5. place this evaluation form in the labeled course envelope, seal it; place the filled course envelope in the stamped envelope and drop it in the mail to us

EVALUATION FORM

Some questions ask for written information, e.g., "list below." Others ask you to answer by circling the code; the codes are as follows"

SA - strongly agree
A - generally agree
U - undecided
D - generally disagree
SD - strongly disagree
I - insufficient information to make a judgement

Immediately following each question, space is provided for a brief explanation of your evaluation; if you need more space, please attach another sheet of paper, marking it clearly with the specific question to which you are responding.

STRONGLY AGREE	SA
GENERALLY AGREE	A
UNDECIDED	U
GENERALLY DISAGREE	D
STRONGLY DISAGREE	SD
INSUFFICIENT INFORMATION TO MAKE A JUDGEMENT	I

1. The title of the course is appropriate to the content.

2. The content of the course, in general, is appropriate to the stated goals of the degree (page in the overview).

3. The content of the course, in general, would be USEFUL in preparing students to be involved in health promotion.

4. The content of the course, in general, is appropriate to the level of an Associate Degree.

5. List below any content of the course which appears to be too elementary for students in an associate degree program:

6. List below any content of the course which appears to be too advanced for students in an associate degree program in health promotion:

7. List below the specific content which is the most important and should not be eliminated:

8. List below any content which you feel is extraneous and <u>should be eliminated</u>:

9. The prerequisites listed for the course seem appropriate.

10. The objectives for the course are stated in a clear and concise manner.

11. The content of the course operationalizes the objectives.

12. The books recommended for the course are appropriate.

13. Please indicate below any books you feel would be more appropriate.

14. If you could change only one thing about this course it would be...

15. Any other general or specific comments?

SAMPLE COMMUNITY EVALUATION
-Program Concept-

HEALTH PROMOTION
KNOWLEDGE, SKILLS, USEFULNESS

1. Suppose Jo Brewster wants to help people in your community live healthier lives, take charge of their own health and make better decisions about their style of life.

   Look through the list below. If an item would be very important for the person described above, mark it with a "+".

   If an item would not be very useful or important, mark it with a "-".

   If you don't know, or if the item is in between "very important" and "not useful", don't mark it at all.

KNOWLEDGE OF

_____ basic mathematic and chemistry
_____ general psychology (understanding human behavior)
_____ human growth and development
_____ processes and problems of adulthood and aging
_____ sociology--group behavior and human relationships
_____ the way basic community social services work
_____ the New Testament
_____ how groups of people work; interpersonal and group relationships
_____ how the human body works, structures and functions
_____ the micro-organisms of man and his environment
_____ the dynamics of the disease process, how diseases spread through a community
_____ fundamentals of human nutrition
_____ how health care organizations work
_____ the current issues/concerns of health care in America
_____ health promotion ideas; methods for helping people change
_____ general treatment of diseases; home care
_____ lifestyle health issues--diet, exercise, stress, drug and alcohol use, smoking
_____ illness--symptoms and major types of treatment

SKILLS IN

_____ expressing ideas in writing
_____ listening and talking to various types of people
_____ basic mathematics and chemistry skills
_____ working in groups of people (small)
_____ techniques of personal responsibility and personal change

paraprofessional skills of health care--
cardiopulmonary resuscitation and treatment of choking
general safety/first aid
home hygiene and sickness care
emotional support, helping upset people

EXPERIENCES IN

listening, talking, evaluating
working in groups
personal health behavior changes
work experience in a community health setting

Circle the best answer to the questions below

II. If a person with the skills and knowledge listed on the first page lived and worked in my community, I think they . . .

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	I DON'T KNOW UNDECIDED
... could help me and my family live a healthier life.	SA	A	D	SD	U
... could be a good resource for our local schools.	SA	A	D	SD	U
... could provide support to families in our community.	SA	A	D	SD	U
... would be useful working in existing medical and social services.	SA	A	D	SD	U
... could do things that doctors, nurses, social workers, and so on don't have time to do.	SA	A	D	SD	U
... could be used by our church to help the community.	SA	A	D	SD	U

SAMPLE STUDENT RESPONSE SHEET

The course you are just completing,
is part of the requirements for graduation for a new 2 year program here at Baptist College in Rural Health Promotion. It would help our evaluation and planning if you could answer the following questions.

1. your major _____
   class _____

2. grade you expect to receive _____

3. grade point average to date for all courses you have taken _____

The new 2 year program in Rural Health Promotion requires core courses in Math, English, Sociology, Psychology, Religion, and Biological Sciences as well as specialized courses in health care. Graduates would work in communities to help people to:

make better health decisions
contact treatment providers
make behavior changes that would enhance health
understand the health need of others

A brochure describing the program is attached.

Please answer the following questions about the course named above based on this information and your student experiences.

4. I feel the knowledge taught by this course would be:
   a. absolutely required for the person described above.
   b. very useful and/or relevant to the person described above.
   c. somewhat useful and/or relevant to the person described above.
   d. of little or no use or relevance to the person described above.

5. I feel the skills/abilities taught by this course would be:
   a. absolutely required for the person described above.
   b. very useful and/or relevant to the person described above.
   c. somewhat useful and/or relevant to the person described above.
   d. of little or no use or relevance to the person described above.

6. Now that you are aware of the new 2 year program - were there ideas, issues, or examples introduced in this course which you can see are obviously related to rural health?

YES NO NOT SURE

7. Did the ideas, issues, or examples which you can now see are specific to rural health fit smoothly into the rest of course?
   a. always
   b. usually
   c. sometimes
   d. seldom

8. Are there other courses at BC you feel would be useful or helpful to take before taking this course. If so, please give general name/title below.

   _____

   _____

9. Are there prerequisites you feel should be required before a person is allowed to take this course? Please note them below.

   _____

   _____

10. Any other comments you think would be useful to the planning and implementation of this project?

Thank you very much for your help.